

# Finance, Philanthropy and the Hospital:

Metropolitan Hospitals 1850-1898

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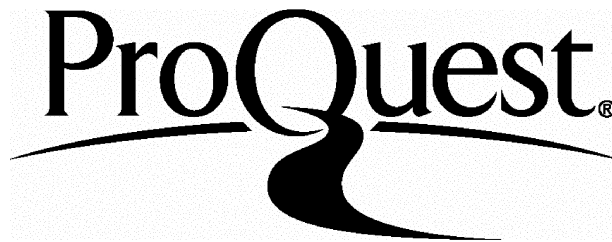
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## Abstract

Hospitals throughout the nineteenth century remained the one of the main channels for the Victorians' voluntary zeal, but from the 1850s onwards tensions emerged as charity became ill-suited to meeting all the hospitals' financial needs. An historiographical survey shows that metropolitan hospitals have been seen as an institution funded and administered through philanthropy, but these views are insufficient. By looking at seven hospitals in London between 1850 and 1898 a different view is suggested.

Hospital governors were adept at manipulating philanthropic interests through their innovative fundraising tactics, playing on a wide range of motivations for benevolent action. Administrators used feelings from guilt to gratitude to promote support, suggesting that philanthropy and contributions cannot be constrained by any simple approach. Using the hospitals' financial records, charitable contributions are placed in the overall context of funding in an institution that drew its income from a wide variety of sources. Over time these sources of funding changed their relative relation to one another in a process of financial diversification. Expenditure, expansion, the financial demands of different hospitals, local charitable resources, competition for funds, and popular perceptions of individual institutions all created pressures on finances that made diversification desirable.

Financial diversification, however, took place in a context where the hospitals' voluntary ethic was not affected. Hospitals experienced administrative expansions as they adopted more medical functions, but management remained on voluntary lines and administrators continued to be drawn from London's wealthy business and social elite. Within this changing managerial structure doctors competed for authority and asserted their influence through a series of internal conflicts which often stressed the importance of medical science. A comparative investigation of the Whitechapel Union shows that a similar process of change occurred. Financial and administrative diversification was therefore more the consequence of institutional healthcare rather than a development limited to the voluntary hospitals.

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## Abbreviations

BMA	British Medical Association
<i>BMJ</i>	<i>British Medical Journal</i>
COS	Charity Organisation Society
FWA	Family Welfare Association
LCC	London County Council
LGB	Local Government Board
MAB	Metropolitan Asylums Board
NHS	National Health Service
<i>PP</i>	Parliamentary Papers
RC	Royal Commission
RCH	Royal Chest Hospital
SBH	St.Bartholomew's Hospital
SC	Select Committee
UCH	University College Hospital

# 1

## Introduction: To Prove a Need

### 1. THE METROPOLITAN HOSPITAL SYSTEM

The publication of the *Tomlinson Report* in 1992 was the ninth in a series of government sponsored investigations into the London hospitals.<sup>1</sup> Following closely behind a survey of primary healthcare by the King's Fund and the government's National Health Service (NHS) reforms, the *Report* generated public interest and a wave of panic among hospital administrators.<sup>2</sup> Over a century ago, in 1890, a Select Committee of the House of Lords was established to investigate similar concerns. The Committee sat for two years and addressed the structure, finance and nature of healthcare in London, concerns that the *Tomlinson Report* returned to. Where the Select Committee vacillated, only weakly recommending a modicum of central supervision and relocation, its twentieth-century counterpart called into question the very pattern of development, organisation of finance, and nature of healthcare in London.<sup>3</sup> In the three years following the *Report's* publication the outpatients' department at St.Bartholomew's has been closed and the fate of Guy's and St.Thomas's remains undecided. The only general hospital in London with a secure future is St.George's after its fortuitous move to Tooting.

The *Tomlinson Report* attempted to deal with problems that had their origin in the healthcare services of Victorian London, where the emphasis was on centralised hospital facilities. Nineteenth-century medical care was divided between philanthropic, public and private provision to create an uncoordinated and competitive 'market' where services were delineated within a structure of actual and perceived inequalities rooted in wealth. The ethos that hospitals functioned to assist 'suitable cases for charity' had already been undermined before 1948, but the institutional legacy of the nineteenth-century system continues to confront health reformers. In the last decade closer parallels have been

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<sup>1</sup> B.Tomlinson, *Report of the Inquiry into London's Health Service, Medical Education and Research* (1992).

<sup>2</sup> *London Health Care 2010: Changing the Future of Services in the Capital* (1992).

<sup>3</sup> SC of the House of Lords on Metropolitan Hospitals, 3rd Report, PP 1892 XIII.

established with the Victorian medical market. Thatcherite economics has encouraged the renewed growth of private healthcare schemes, if not a return to the principle of less eligibility, and the state has started to devolve its statutory obligations. Hospitals have been encouraged to opt out of regional control and establish self-governing trusts with claims to an independent management of resources. However, this is a poor reflection of the Victorian hospitals. Administrators are not the 'subscriber democracy' of nineteenth-century voluntary associations, but the direct appointees of the government accountable only to Whitehall. According to Finlayson ample room has always remained for voluntary activity within the welfare state and the state is still willing to tap the assets of the benevolent.<sup>4</sup> The Resources Allocation Working Party when searching for new sources of income in 1975 turned to charity to 'bail out a debilitated health service'.<sup>5</sup> In 1987/8 charitable resources within the NHS produced an annual income of £130 million from rents and dividends. Non-NHS charities contributed a further £200 million and voluntary effort alone saved the NHS a further £24,000 million.<sup>6</sup> These contributions have blurred the independent status of philanthropy, but reflect the central role voluntarism played in Victorian healthcare.

Health has been offered in many forms, few of them initially located in the hospital.<sup>7</sup> In the name of health 'Victorians flocked to the seaside, tramped about the Alps or Cotswolds, dieted, took pills, sweated themselves in Turkish baths, adopted this "system of medicine" or that'.<sup>8</sup> It was not an irrational or hypochondriac preoccupation in an age where few people could enjoy good health and no family, no matter what their social status, seemed safe from illness. Wohl's *Endangered Lives* reveals a world rooted in congestion, pollution, overcrowding, and disease with manifold possibilities for death.<sup>9</sup>

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<sup>4</sup> G.Finlayson, 'A Moving Frontier: Voluntarism and the State in British Social Welfare 1911-1949', *Twentieth Century British History*, 1 (1990), 194.

<sup>5</sup> F.K.Prochaska, *Philanthropy and the Hospitals of London* (Oxford, 1992), 229.

<sup>6</sup> L.Fitzherbert, *Charity and the National Health Service* (1989), 11-17.

<sup>7</sup> See R.Porter, 'The Patient's View: Doing Medical History from Below', *Theory and Practice*, 14 (1985), 175.

<sup>8</sup> B.Haley, *The Healthy Body and the Victorian Culture* (1987), 3.

<sup>9</sup> A.S.Wohl, *Endangered Lives: Public Health in Victorian Britain* (1984).



*The Times* reported in 1868 that the ‘growth of civilisation means the growth of towns, and the growth of towns means, at present, a terrible sacrifice of human life’.<sup>10</sup> This picture tends to become too bleak. The scholarly journalist T.S.Escott saw a ‘blessed’ transformation throughout the nineteenth century with an improvement in urban sanitary conditions in response to public health crusades and rising living standards. For proof he cited the fall in mortality from 23 per thousand in 1855 to 18 per thousand in 1895.<sup>11</sup> While sanitary reformers of the day attempted to deal with the problems at their origin; hospitals, later assisted by the Poor-law infirmaries, contented themselves with dealing with the more immediate outcome.<sup>12</sup>

The problems experienced by the Victorians were peculiar to rapid urbanisation and industrialisation, but the hospital has a long and varied history. The first authentic hospital in Britain was established at York in 947, but it was not until Rahere’s foundation of St.Bartholomew’s in 1123 that an institution was created specifically as a hospital and not as a hostel for travellers and pilgrims.<sup>13</sup> A hospital boom occurred in the early eighteenth century and the extent of disease and ill-health in the nineteenth century pressurised Victorians into institutionalising medical services. Evolution was haphazard and erratic, responding to concerns over mortality and morality. Humanity, self-interest, religion, and the pursuit of social status made common cause to help those deemed unable to meet the cost of private medical care, to which the ethic of *laissez-faire* would otherwise have committed them. London was at the centre of these developments. It was only from the 1850s onwards that the hospitals’ medical and administrative functions began to develop beyond the simple institutional arrangements needed to dispense relief to the sick poor. The charitable nexus between the hospital, the governors, the doctors, and the patients, evolved into a complex set of service relationships which increasingly

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<sup>10</sup> Cited in J.Woodward, *To Do the Sick No Harm* (1974), 65.

<sup>11</sup> F.B.Smith, *The People’s Health* (1979), 414.

<sup>12</sup> See S.Szreter, ‘The Importance of Social Intervention in Britain’s Mortality Decline c. 1850-1914’, *Social History of Medicine*, (1988) and A.Hardy, *Epidemic Streets* (Oxford, 1993) for the positive role the public health movement played. S.Guha, ‘The Importance of Social Intervention In England’s Mortality Decline: The Evidence Reviewed’, *Social History of Medicine*, 7 (1994) presents an alternative view.

<sup>13</sup> Woodward, *To Do the Sick No Harm*, 1.

underwent managerial subdivision and bureaucratisation. Hospitals were transformed from 'places which healthy people should avoid and the sick should shun', to expensive institutions for the treatment of illness.<sup>14</sup> Contemporary attitudes lagged behind institutional and medical developments, though by the end of the nineteenth century opinion no longer saw hospitals as 'gateways to death'.<sup>15</sup> Philanthropists unlike patients, however, had always viewed hospitals with pride. For Henry Burdett, the 'Pope' of charity, these institutions and 'not our bridges, or railways or telephones, but the great fortresses of science and benevolence erected where suffering most abounds, are the real glory and abiding distinction of our civilisation'.<sup>16</sup>

Hospitals gradually moved away from their clerical and philanthropic roots into the mainstream of medical care. Anaesthetics, antiseptics, scientific medicine, and nursing helped alter the public's low opinion of the hospital and made them into centres of medical education and sophisticated medical provision.<sup>17</sup> Hospitals, according to Rosenberg, were influenced at all levels, requiring a change in orientation as both

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<sup>14</sup> This is reflected in the record keeping procedures which moved beyond minutes and lists to clinical reports and complex schedules: B.Craig, 'A Survey and Study of Hospital Records and Record Keeping in London (England) and Ontario (Canada) c. 1850-1950' (Unpublished PhD thesis, University of London, 1988).

<sup>15</sup> G.Rivett, *The Development of the London Hospital System* (1986), 102. Such conceptions have been projected into the debate around McKeown's work that sees that 'on balance the effects of hospital work in this period were probably harmful': T.McKeown & R.Brown, 'Medical Evidence Related to English Population Changes in the Eighteenth Century', *Population Studies*, 9 (1955), 119. It must, however, be noted that hospitals would naturally have a higher mortality than the surrounding population given the concentration of disease. More recent research fails to justify McKeown's harsh judgement, see S.Cherry, 'The Hospitals and Population Growth', *Population Studies*, 34 (1980) and J.Woodward, *To Do the Sick No Harm*, 124-146.

<sup>16</sup> H.C.Burdett, *Hospitals and Charities Annual* (1895), 3; for a biographical account of Burdett see Rivett, *Development of the London Hospital System*, 373-4.

<sup>17</sup> For a more extensive treatment of the advances in medical practice see chapter six, though A.Youngson, *The Scientific Revolution in Victorian Medicine* (1979) and C.Lawrence (ed.), *Medical Theory, Surgical Practice* (1992) provide a conflict based analysis of medical advance. B.Abel Smith, *A History of the Nursing Profession* (1960) offers a general survey of nursing and C.Helmstadter, 'Robert Bentley Todd, Saint John's House, and the Origins of the Modern Trained Nurse', *Bulletin of the History of Medicine*, 67 (1993) studies the influence of the nursing sisterhoods on the development of nursing.

governors and medical staff increasingly came to view themselves as providers of medical treatment, not as moral or social reformers.<sup>18</sup> Slowly hospitals overcame their institutional inertia and adjusted to changing demands to become the accepted work place for doctors and a solution to the demands for institutionalised care removed from treatment within family. Medical men, concerned to advance their careers, attached themselves to hospitals, viewing the London poor as useful material for clinical study and hospitals as a necessary arena for practice. However, it was not until the establishment of the Metropolitan Asylums Board (MAB) in 1867 that any systematic effort was made to provide public institutions for the sick.<sup>19</sup>

## 2. HISTORIANS AND THE HOSPITAL

Hospitals formed, in Granshaw's words a 'microcosm of Victorian society'.<sup>20</sup> However, research has only recently begun to look beyond the hospital's role in the development of modern medicine. The *Wellcome History of Medicine Bibliography* has over 340 references to hospitals, but studies placing development in a broad context are less numerous than individual institutional histories. Writing on hospitals has been dominated by medical historians who have sought to explain development in medical terms, not to question the hospital as a social and charitable institution. Early general studies by Evans and Howard, Dainton, and Risley are notoriously whiggish and were never intended to be analytical studies.<sup>21</sup> Lord Amulree, in the foreword to Dainton's book, claimed that 'the subject seems to have been generally neglected'; Dainton himself covered development from the middle ages to the foundation of the NHS in under two hundred pages. Useful

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<sup>18</sup> C.E.Rosenberg, *The Care of Strangers* (New York, 1980) and H.Sigerist, 'An Outline Development of the Hospital', *Bulletin of the Institute of the History of Medicine*, 4 (1936) tie the development of modern medicine to the evolution of improved medical practices.

<sup>19</sup> R.G.Hodgkinson, *The Origins of the National Health Service* (1967), 620-680.

<sup>20</sup> L.Granshaw, 'St.Thomas's Hospital: London 1850-1900' (Unpublished PhD Thesis, Bryn Mawr College, 1981), 9.

<sup>21</sup> A.Evans & L.Howard, *Romance of the British Voluntary Hospital Movement* (1930); C.Dainton, *The Story of English Hospitals* (1961); M.Risley, *House of Healing* (1962).

general studies, however, do exist. Brian Abel Smith provides a classic account of hospital development.<sup>22</sup> Focusing on the structure of administration and the role of the medical profession, his analysis synthesises all aspects of development from nursing to therapeutic practice to produce a long ranging study. Woodward's study *To Do the Sick No Harm* is more precise. He reevaluates the hospitals' image as 'gateways to death' to counter McKeown's derisive view institutional healthcare. However, his focus on the ideas of Nightingale, Bristowe and Holmes, on the restrictions individual hospitals placed on admissions, and his arbitrary end in 1875 does little to explain the evolution of the voluntary hospital system. Rivett's survey *Development of the London Hospital System* does, in part, do this for London. He explains how the capital's medical services were increasingly systematised, a process that gradually merged philanthropic, public and private strategies of care and culminated in the NHS. Rivett addresses the financial problems facing London's hospitals and the increasing interest contemporaries showed in hospital reform.<sup>23</sup> However, where he assesses philanthropy's role in healthcare, the breadth of his study hardly gives charity the position it deserves. Pickstone's work on medical care in Manchester and Marland's study of Huddersfield and Wakefield provide two other detailed regional studies.<sup>24</sup> Pickstone assesses the growth of medical provision from the eighteenth century to the 1940s, linking development to social and economic conditions, especially public health concerns. Marland's work investigates medical charity and care in relation to society, social groups and status. The Wakefield Dispensary and the Huddersfield Infirmary were not the chief focuses of her study, but she effectively explored the motivations behind support for medical charity and the types of people who offered their time and money to the two institutions. Her balanced view, which stresses the commercial background to medical charity, points to an important approach that emphasises the contribution of society and not just the medical profession to hospital development.

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<sup>22</sup> B. Abel Smith, *The Hospitals 1800-1948* (1964).

<sup>23</sup> Rivett, *Development of the London Hospital System*, 118-52.

<sup>24</sup> J.V. Pickstone, *Medicine and Industrial Society* (Manchester, 1985); H. Marland, *Medicine and Society in Wakefield and Huddersfield* (Cambridge, 1987).

Individual London hospitals have their own in-house histories written mostly by doctors fired by their institutional allegiances.<sup>25</sup> In 1861 Wakley, founder and editor of the *Lancet*, deplored the absence of institutional accounts; now the situation has been almost completely reversed.<sup>26</sup> In such accounts the hospital is viewed in a vacuum, not as a social or historical phenomenon, but as a vehicle for distinguished doctors, prominent men, and as a site for important clinical and nursing advances. This partly reflects the period when most of these studies were written, acting as a lament for the voluntary system after the foundation of the NHS, or to mark an important institutional anniversary. Not all studies are so narrow. Clark-Kennedy's two-volume history of the London attempts to provide a social history of London's largest hospital, its internal divisions, and responses to the changing social and physical environment of the East End.<sup>27</sup> It remains, however, a history commissioned by the hospital and royal occasions, personalities, cholera, and new buildings dominate the narrative. Despite Langdon Davis's effort to place the Westminster in an economic, social and political setting, only Lindsay Granshaw, in her scholarly examination of St.Thomas's, provides a realistic picture of one of London's leading teaching hospitals.<sup>28</sup> Her intention was to locate St.Thomas's within a social and medical analysis, investigating the class structure of those admitted and the nature of the non-medical administration.<sup>29</sup> Granshaw's social history of St.Mark's Hospital for Fistula retains a narrative focus and concentrates on prominent physicians, especially its founder Frederick Salmon, but it provides a valuable insight into the

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<sup>25</sup> For example see T.Higgins, *Great Ormond Street* (1952) and H.C.Cameron, *Mr Guy's Hospital: 1726-1948* (1954), or those histories written to mark an important hospital anniversary W.R.Merrington *University College Hospital and its Medical School*, (1976); T.G.Davies, *Deeds Not Words: A History of the Swansea General and Eye Hospital 1817-1948* (Cardiff, 1988)

<sup>26</sup> *Lancet*, 2 (1861), 481.

<sup>27</sup> A.E.Clark-Kennedy, *The London* (1963).

<sup>28</sup> J.Langdon Davis, *Westminster Hospital* (1952).

<sup>29</sup> Granshaw, 'St.Thomas's'.

evolution of a specialist hospital, an analysis she develops in a later article.<sup>30</sup> For Granshaw, specialist institutions evolved in response to the professional monopoly of the large general hospitals. It was enterprising medical men, excluded from profitable positions at existing institutions by the corrupt system of internal appointments, who founded specialist hospitals. Contemporaries accused those doctors associated with specialist hospitals of Machiavellianism, but for them these institutions were a solution to restrictions and frustrations, allowing those at the edge of the medical world to advance their careers through a hospital appointment.<sup>31</sup>

There is more to the history of hospitals than prominent men, royal occasions, rebuilding, or their relation to the evolution of medical science. Increasingly, they were integrated into the career patterns of practitioners, providing the key forum for clinical experience, medical development and training as medical education moved away from the old private medical schools and dispensaries into the hospital.<sup>32</sup> Hospitals were part of the professionalisation of medicine, and doctors' attempts to gain professional status and authority helped shape the hospital's internal environment.<sup>33</sup> With many fields of activity

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<sup>30</sup> L.Granshaw, *St.Mark's Hospital, London: A Social History of a Specialist Hospital* (1985); "'Fame and Fortune by Bricks and Mortar": The Medical Profession and Specialist Hospitals in Britain 1800-1948' in L.Granshaw & R.Porter (eds.), *The Hospital in History* (1989).

<sup>31</sup> Exceptions can be found. Charing Cross Hospital was established by a medical student, Benjamin Golding, from philanthropic motives, and its teaching nature and need for general cases removed the usual impetus towards specialism: See R.Minney, *Two Pillars of Charing Cross* (1967).

<sup>32</sup> See C.Newman, *Evolution of Medical Education in the Nineteenth Century* (1957); I.Loudon, 'The Origins and Growth of the Dispensary Movement in England', *Bulletin of the History of Medicine*, 55 (1981).

<sup>33</sup> There has been comparatively little historical writing on the process of professionalisation though it was an undoubted characteristic of the period. One of the best studies is W.J.Reader, *Professional Men, The Rise of the Professional Classes in Nineteenth Century Britain* (New York, 1966). More has been written from a sociological perspective such as M.S.Larson, *The Rise of Professionalism* (1978) or J.Jackson (ed.), *Professions and Professionalism* (Cambridge, 1970). All argue that by the end of the nineteenth century professionalism had become a dominant feature of certain careers, expanding beyond the tradition sectors of the church, medicine and law. H.Perkin, *The Rise of Professional Society: England Since 1880* (Princeton, 1989) goes further, arguing that from the 1880s onwards it was the professional ideal that gradually replaced the

moving towards Greenwood's minimum criteria for professional status, the medical profession was slow to acquire unity.<sup>34</sup> Only from 1858 were doctors forced to register and they remained a stratified occupation riddled with internecine feuds even if the British Medical Association (BMA), the *Lancet*, and the *BMJ* gave an outward appearance of unity. Peterson provides a comprehensive survey of the medical profession in mid-Victorian London. She places the hospital at the centre of the conflict between the emergent general practitioners and the status conscious consultants.<sup>35</sup> Regrettably, her work ends in the 1870s. Parry adopts a similar interpretation and places professionalisation within a broad sociological framework.<sup>36</sup> Others have illustrated development in relation to government bureaucracy where doctors were gradually introduced into various departments, principally the Poor Law and public health sectors, as specialists and advisors.<sup>37</sup> The hospital therefore developed an increased significance for the medical profession and provided a vital arena for clinical practice, experience and treatment. The precarious economic position of the medical profession outlined by Digby provided a further dimension.<sup>38</sup> Many doctors wanted to be associated with a hospital as they provided status, income, and access to expanded practices. In response doctors gradually assumed a more prominent role in hospital management as it gradually changed to match their criteria.

Smith believes that patients are 'the off-stage army in the drama of medical advance: the necessary adjuncts as clinical material and sources of income to the heroes and heroines of the story, doctors, administrators and nurses'; they are not alone in their

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middle class and industrial conception of society. However, he places the real transition in the twentieth century.

<sup>34</sup> Greenwood argued that an occupation was a profession when it had: a systematic theory, authority, community sanction, a code of ethics, and a professional culture: F.Greenwood, 'Attributes of a Profession', *Social Work*, 2 (1957).

<sup>35</sup> M.J.Peterson, *The Medical Profession in Mid-Victorian London* (Berkeley,1978).

<sup>36</sup> N.Parry, *The Rise of the Medical Profession* (1988).

<sup>37</sup> S.Novak, 'Professionalism and Bureaucracy', *Journal of Social History*, 6 (1973).

<sup>38</sup> See A.Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine 1720-1911* (Cambridge, 1994).

historical obscurity.<sup>39</sup> The history of the hospital has been seen mainly from above, primarily doctor-orientated. Society is largely absent, administration and finance are glossed over to provide nothing more than backdrops to what are considered more important medical developments. This tells us little about the true breadth of the medical world or the hospital's administrative and financial environment. Medical services did not develop in isolation and hospitals were established only partly to reflect medical needs. It was often laymen rather than practitioners who campaigned and founded medical institutions, and as Chapter 5 shows, it was they who dominated the administration in a social climate in which voluntarism was revered. Even specialist hospitals were founded with philanthropic support. The medical profession's position in the hospital was shaped as much by social attitudes to medicine as by technological advances and desires for status. Although the governors' important position is recognised, it is seldom explained.

Hospitals were not insular institutions separate from society. In providing medical relief to the sick poor, they were part of the philanthropic world, an institutional intermediary between the charitable and the recipients of relief. The nineteenth century was 'the age of charitable societies' and the philanthropy was a source of national pride. Surveys of charitable societies in London revealed an abundance of often competing voluntary organisations for every social ill.<sup>40</sup> The Victorian mind ascribed social problems to individual inadequacies or exceptional circumstances. Structural faults in society and the economy were not acknowledged and faith was placed in the curative value of self-help and charity.<sup>41</sup> The solution was personal intervention rather than bureaucratic involvement and those that could not or would not be helped became the responsibility of the state through the Poor Law. Booth's surveys of London in the 1890s hinted at philanthropy's inadequacies and pointed to areas of acute poverty despite the dramatic increase in the number of voluntary organisations, but the preeminence of charity meant that it continued to mitigate the worst consequences of the urban environment. It was

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<sup>39</sup> Smith, *Peoples' Health*, 9.

<sup>40</sup> S.Low, *The Charities of London* (1850); W.F.Howe, *Twenty-Forth Annual Edition of the Classified Directory to the Metropolitan Charities for 1899* (1899).

<sup>41</sup> Prochaska, *Philanthropy*, 1.



within this benevolent economy, where charitable resources were located and competed for, that hospitals were established, evolved and operated. Medical charity was one of the main channels for the Victorians' benevolent zeal.

Historians have debated the nature of philanthropy and Finlayson has divided voluntarism into four sectors: individual, commercial, informal and statutory.<sup>42</sup> The voluntary sector has been mainly associated with individual philanthropy, either 'self-regarding' in mutual aid societies, or 'other-regarding' in non-profit distribution through benevolent societies, though this should not preclude unaccounted for individual benevolence, especially by the working classes.<sup>43</sup> While many historians have written about charity, the motives behind philanthropy remain difficult to unravel. Owen's important study portrays the expanse and development of Victorian benevolence, but he believes the reasons for philanthropy are elusive.<sup>44</sup> Jordan goes as far as to believe that the inspiration for benevolent action 'remains buried deep in the recess of our nature, immune, perhaps happily, from the fumbling probing of the historian'.<sup>45</sup> Interpretations vary, as discussed in Chapter 2, though few have adopted Bremmer's approach in detailing writers' and novelists' attitudes to charity from antiquity to the present.<sup>46</sup> Others have preferred to limit their investigation. Andrew has argued that by the end of the eighteenth century charity had undergone a transformation. Philanthropy had moved away from posthumous bequests to become an agent of 'national regeneration', aiding the development of character and reforming the minds and morals of the labouring poor.<sup>47</sup> According to Yeo a further transformation occurred from the 1870s onwards when Andrew's 'associated charities' began to undergo a crisis, losing vitality and justification

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<sup>42</sup> G.Finlayson, 'A Moving Frontier: Voluntarism and the State in British Social Welfare 1911-1949', *Twentieth Century British History*, 1 (1990), 183-5.

<sup>43</sup> P.Mandler, 'Poverty and Charity in the Nineteenth Century Metropolis' in P.Mandler (ed.), *The Use of Charity* (Philadelphia, 1990).

<sup>44</sup> D.Owen, *English Philanthropy 1660-1960* (Cambridge, Mass., 1964).

<sup>45</sup> W.Jordan, *Philanthropy in England 1480-1660* (1959), 144.

<sup>46</sup> R.H.Bremmer, *Giving: Charity and Philanthropy in History* (New Brunswick, 1994).

<sup>47</sup> D.Andrew, *Philanthropy and Police: London Charity in the Eighteenth Century* (Oxford, 1989).

in the face of new assertive working-class movements.<sup>48</sup> Morris believes that benevolence formed a 'subscriber democracy' which assisted bourgeois integration and provided a solution to the problems of emergent industrialism.<sup>49</sup> Philanthropy has equally been seen as an extension of paternalism and for some a means of social control. Prochaska has perhaps done most to analyse the nature of philanthropy. His study of Victorian women and benevolence places charity within a humanitarian context, where it became an opportunity for women to find a positive and active role within society's preconceptions of the female role.<sup>50</sup>

Hospital governors' authority was defined by their philanthropic credentials. Charity provided the *raison d'être* for their control of hospital management, but scant attention has been paid to the role of benevolence in the hospital. Hart has attempted to outline the philanthropic principles behind the hospitals' admissions system, but the study is far from comprehensive.<sup>51</sup> The undoubted importance of charity in hospital funding has blurred a realistic analysis of the contours of hospital income. Rivett does offer a brief account of the London hospitals' financial problems and the development of the Prince of Wales Hospital Fund for London, whose history Prochaska has studied in *Philanthropy and the Hospitals of London* (Oxford, 1992).<sup>52</sup> The Prince of Wales Hospital Fund was founded in 1897 and attempted to solve the problems of the nineteenth century; its history, however, is largely that of the twentieth. No similar investigation has been undertaken for the earlier work of the Metropolitan Hospital Sunday Fund and the Metropolitan Hospital Saturday Fund which pioneered a model of organised funding and reform that the Prince of Wales Hospital Fund extended. Cherry has, however, analysed the important

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<sup>48</sup> S.Yeo, *Religion and Voluntary Organisations in Crisis* (1976).

<sup>49</sup> R.J.Morris, *Class, Sect and Party: The Making of the British Middle Class, Leeds 1820-50* (1990).

<sup>50</sup> F.K.Prochaska, *Women and Philanthropy in Nineteenth-Century England* (1980).

<sup>51</sup> H.Hart, 'Some Notes on the Sponsoring of Patients', *Medical History*, 24 (1980).

<sup>52</sup> Rivett, *Development of the London Hospital System*.

role workers' contribution schemes played in twentieth-century hospital finance.<sup>53</sup> Individual hospital histories offer some passing mention of hospital finance, but few match Borsay's work on the Bath Infirmary in the mid-eighteenth century.<sup>54</sup> Philanthropy itself has received short shrift and medical advance has biased the interpretation of professionalisation. Administration and internal conflicts between doctors and governors have been minimised. It is therefore to these omissions that this thesis addresses itself. It seeks to place itself within a new strand of historical inquiry that attempts to locate the hospital within a wider context of voluntarism and contribute to the understanding of charity and the nature of the London benevolent economy.<sup>55</sup>

### 3. DIMENSIONS OF STUDY

London between 1850 and 1898 provides the focus for this thesis. Regional studies of medical care and philanthropy stress the local nature of charitable provision. Regional and urban benevolent economies were shaped by the locality's social and economic development to produce different networks of voluntarism. London was no different. Its diverse economic, social and physical structure created a benevolent economy that was at once highly localised, national and international. The particular qualities of the metropolis captivated contemporaries. To Dickens, Disraeli and Tennyson it was a city like no other; Bagehot equated London with a newspaper: everything was there and

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<sup>53</sup> K.Waddington, '"Bastard Benevolence': Centralisation, Voluntarism and the Sunday Fund 1873-1898', *London Journal*, 19 (1995), 151-67 analyses the Metropolitan Hospital Sunday Fund's impact on hospital funding and reform, while S.Cherry, 'Beyond National Health Insurance. The Voluntary Hospitals and Hospital Contributory Schemes: A Regional Study', *Social History of Medicine* 5 (1992) studies the role of workers' contribution schemes in hospital funding in the twentieth century.

<sup>54</sup> A.Borsay, 'Cash and Conscience: Financing the General Hospital at Bath c 1738-1750', *Social History of Medicine*, 4 (1991).

<sup>55</sup> Research now being undertaken by Amanda Berry 'Charity, Patronage and Medical Men: Philanthropy and Provincial Hospitals' (Oxford, DPhil), Dr Anne Borsay at Lampeter, and Martin Gorsky, 'Philanthropy in Bristol 1800-50' (Bristol, PhD) has started to study hospital finance and consider the hospital as a social institution.

nothing was connected to anything else.<sup>56</sup> The author of *Suffering London* felt that London was the 'pale spectre', an 'agglomeration of energy [that] should present a panorama of life and activity intense enough to strike the minds of strangers with awe and admiration'.<sup>57</sup> London defied precise definition and was a city of contradictions. Under the 1855 Metropolitan Management Act metropolitan London covered 118 square miles, but continuous physical expansion ensured that it had no fixed boundaries. Overshadowed politically and economically by the 'shock cities' of the north in the early nineteenth century, London retained a growing economy and remained a 'world city', the centre of national political power and fashionable society, but with acute social problems that dominated debates on poverty, housing and employment from the 1880s onwards. According to Garside, London was 'central yet peripheral, economically secondary yet socially dominant, culturally inspirational yet parasitic'.<sup>58</sup>

The London economy was self-generating and successful, biased towards consumer-oriented enterprises largely organised in small workshops, the service sector, and specialist financial and banking activities centred on the City from which it led the domestic and international money markets. However, it was not immune from fluctuations. The speculative bubble of the 1860s culminated in the collapse of Overend & Gurney and in the mid 1880s workers took to the West End to protest about the high levels of unemployment. London's labour market was sporadic and the economy was specialised and interdependent, relying above all on its own market.<sup>59</sup> Localism prevailed at all levels. Despite improvements in transport, for many workers 'all that lay beyond a tiny circle of personal acquaintance or walking distance was darkness'.<sup>60</sup> Social fragmentation was more acute: London was a city kept together by the 'irrigations of

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<sup>56</sup> Cited in P.Garside, 'London and the Home Counties' in F.M.L.Thompson (ed.), *Cambridge Social History of Britain: 1750-1950*, 3 (Cambridge, 1990), 489.

<sup>57</sup> A.E.Hake, *Suffering London* (1892), 3.

<sup>58</sup> Garside, 'London and the Home Counties', 490.

<sup>59</sup> See H.J.Dyos, 'Greater and Greater London' in J.S.Bromley & E.H.Kossman (eds.), *Britain and the Netherlands* (The Hague, 1971).

<sup>60</sup> E.J.Hobsbawm, 'The Nineteenth Century London Labour Market' in R.Glass (ed.), *London: Aspects of Change* (1964), 8.

commercial capital'.<sup>61</sup> Many areas had a village-like character and the Victorian Londoner, according to Davies, remained 'long diffident about his metropolitan identity'.<sup>62</sup> Urban and suburban growth separated classes and deliberate estate policy created social enclaves.<sup>63</sup> London's inner areas were transformed by street improvements, railways and later by slum clearances, dispersing the middle classes to the suburbs and concentrating the working classes dependent on local employment in the centre. Social and geographical separation created concerns about social harmony that acted as a stimulus to philanthropy.

This broad description of London is highly generalised. Localism created micro districts and economies, and each parish deserves its own comprehensive history. However, the benevolent economy was part of these wider trends in development and at the same time linked to local situations. Both had a marked impact on hospital income, influences which are discussed in more detail in Chapter 4. The dichotomies of wealth and poverty shaped London's benevolent economy: economic fluctuations defined the amount of charitable resources available, and urban development helped define attitudes to philanthropy and influenced the extent of local philanthropic resources.

Hospitals were a crucial part of this benevolent economy. No other city in Victorian Britain offered the diversity of medical services in a single urban context. Rivett has shown that the structure of institutional healthcare in London was the most advanced and comprehensive system, particularly in the specialist sector. London's hospitals provided the model for the rest of England.<sup>64</sup> An analysis of the entire financial and administrative structure of healthcare in London is beyond the scope of this investigation. In 1809 London could boast seven general hospitals, four lying-in and two

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<sup>61</sup> H.J.Dyos & D.Reeder, 'Slums and Suburbs' in H.J.Dyos & M.Wolf (eds.), *The Victorian City* (1973), 359.

<sup>62</sup> J.Davis, *Reforming London: The London Government Problem 1855-1900* (Oxford, 1988), 5.

<sup>63</sup> See F.M.L.Thompson, *Hampstead: Building a Borough 1650-1970* (1978) or H.J.Dyos, *Victorian Suburbs: A Study of the Growth of Camberwell* (Leicester, 1967).

<sup>64</sup> Rivett, *Development of the London Hospital System*.

for infectious diseases, mostly founded during the eighteenth century.<sup>65</sup> In 1890 provision had expanded to include 21 general hospitals, 11 of these with medical schools, 67 specialist hospitals.<sup>66</sup>

Table 1.1: Increase in London Hospital Treatment (percent: 1973=0)

Year	Population increase	Inpatients increase	Outpatients increase	Total
1883	15.6	26.3	17.4	18.0
1893	10.3	35.1	49.9	48.7
TOTAL	26.6	71.1	76.0	75.7

Source: Burdett, *Hospitals*, 83.

This, however, fails to produce a complete picture of the institutional medical services available. Hospitals were not the main providers of healthcare in London although they did attract a disproportionate amount of contemporary attention. In 1896 58,550 sick poor were treated under the Poor Law, 22,100 in separate infirmaries.<sup>67</sup> The myriad of provident and free dispensaries and the friendly societies treated many more patients, numbers that are not amenable to quantitative analysis. The medical market in London was therefore a complex and stratified one. Workhouse infirmaries existed side-by-side with hospitals, between them was the numerous private practices from the fashionable Harley Street to the warrens of St.Giles. Concentration was greater in north London, for ten of the fifteen largest hospitals, with three quarters of the beds, were within one mile of the Charing Cross.

Classification, partly produced by contemporaries and partly imposed by historians, moves somewhat towards providing a structure within which London's hospitals can be analysed. Classification allows a rationalisation of a pattern of development that was far from systematic. The basic definition of a hospital is provided by the World Health

<sup>65</sup> Rivett, *Development of the London Hospital System*, 25.

<sup>66</sup> SC on Metropolitan Hospitals, 1st Report, 3-4.

<sup>67</sup> F.Cartwright, *A Social History of Medicine* (1977), 159.

Organisation: 'an establishment which offers accommodation and provides medical and nursing care to persons who are sick or injured, or are suspected of being sick or injured'.<sup>68</sup> As a twentieth-century construct, this provides a rough working definition but leaves out the Victorian hospitals' voluntary nature. Woodward goes further to define a voluntary hospital as dependent on charitable contributions rather than on endowments for financial support: subscribers, rather than a President or Governors appointed by charter, formed the administration; medical staff held honorary positions, receiving no salary and patients were not required to pay fees.<sup>69</sup> For Wakley hospitals were 'first to harbour and give medical and surgical succour to a certain number of patients; and secondly, to promote the interests of science and train up a constant succession of medical practitioners for the community at large'.<sup>70</sup> The first definition covers the broad spectrum of medical services, but Woodward's is a closer approximation to their actual management. Wakley's definition reflects the medical profession's concerns, but outlines one of the hospital's major functions as a vital resource for clinical training. Hospitals modelled themselves on the voluntary system and provided treatment within the parameters of the benevolent economy. Poor-law infirmaries did the same, but within the restrictions of a state conception of poverty.

Subdivisions are apparent within these definitions: hospitals were far from uniform. When it delivered its final report in 1892, the Select Committee on Metropolitan Hospitals adopted five classifications: endowed, teaching, general, specialist, and Poor Law.<sup>71</sup> These categories can be further subdivided. Endowed hospitals derived their income primarily from property and investments with a minimal reliance on voluntary contributions. This produced an administration different from the 'subscriber democracy' of other hospitals. Foundation dates offer a convenient means to distinguish these institutions, though these hospitals can also be classified by those that were later forced to solicit money from philanthropy. The first distinction is more satisfactory as it reflects the divisions in

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<sup>68</sup> R.Pinker, *English Hospital Statistics 1861-1938* (1966), 3.

<sup>69</sup> Woodward, *To Do the Sick No Harm*, 12.

<sup>70</sup> *Lancet*, 1 (1858), 416.

<sup>71</sup> SC on Metropolitan Hospitals, 3rd Report, 13.

administration. Both St.Bartholomew's and St.Thomas's were old institutions re-founded under Henry VIII in the wake of the dissolution of the monasteries. Guy's was a product of the eighteenth century and though established during the founder's lifetime, it drew its character and income from his posthumous bequest at a time when philanthropy, rather than religion or the state, was establishing medical institutions. A similar separation occurs within general hospitals. General hospitals adopted the main managerial characteristics that their predecessors had pioneered and infused them with a voluntary ethic that linked service to a financial contribution. However, they can be distinguished at a more fundamental level. Many eighteenth-century hospitals later established medical colleges that were loosely attached to the hospital, though funded separately. In the nineteenth century, specific teaching hospitals were established like King's College Hospital and Charing Cross Hospital which provided charitable healthcare within an educational framework. General hospitals not founded with an educational purpose in mind were slow to adopt a teaching role, creating a functional and chronological split between institutions.

Specialist hospitals are the most amorphous category. The Select Committee defined them as:

one which is restricted to the treatment either of a particular disease, or class or group of diseases, or of particular classes of patient... or, again, it may be special, not as regards the kind of disease, not as regards the kind of disease treated, but as regards either its effect upon the patients... or on the particular methods adopted for its treatment.<sup>72</sup>

Hence the London Temperance Hospital, the Belgrave Hospital for Children, and the Royal Eye Hospital, were all specialist institutions. One key factor was that they were all generally inspired by a doctor rather than by a group of philanthropists. This had important implications for their management, though it also aroused hostility and accusations of careerism.<sup>73</sup> The Select Committee's definition, however, excluded ethnic hospitals. This is not surprising, ethnic hospitals only loosely matched the definition of a hospital. The French and Italian Hospitals were more hospices than medical institutions,

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<sup>72</sup> SC on Metropolitan Hospitals, 3rd Report, lv-lx.

<sup>73</sup> See Granshaw, "Fame and Fortune by Bricks and Mortar".



though the German Hospital was different. These institutions were founded by wealthy or naturalised immigrants for the benefit of London's alien communities. They aimed to provide medical relief within an environment where immigrants' religious, cultural and linguistic differences were catered for.

Boundaries between the different hospital types were not as rigid as this classification suggests. General hospitals leisurely adopted specialist functions through the formation of internal specialist departments arising from outpatient facilities. University College Hospital established an eye infirmary in 1846; Guy's opened an aural department in 1863.<sup>74</sup> Endowed hospitals served not only as general institutions, but also developed teaching facilities, as did the Hospital for Sick Children.<sup>75</sup>

Ideally, a study of the entire edifice of medical provision in London throughout the nineteenth century would be preferable, but the dimensions of such an investigation would be overwhelming. The period 1850 to 1898 has been selected because London's hospitals entered a transitionary period in which the changes outlined above occurred. During this period the Sunday Fund and Saturday Fund were founded and hospitals experienced a need to diversify their income in a situation where '*income barely keeps pace with the unavoidable expenditure* [author's italics]'.<sup>76</sup> It witnessed not only the development of more scientific practices, forcing institutions to conform to different standards, but also saw the expansion of the medical profession and a change in social attitudes towards medicine. Under these conditions hospitals were increasingly seen as a viable location for medical relief, even if there was not the sudden influx of middle-class patients that contemporaries feared. 1898 was a significant year for hospitals. In 1898 the Prince of Wales Hospital Fund had completed its first year. With the Fund a new era in active philanthropic control was ushered in, partly in response to fears over state intervention. It used grants to influence policy and organisation to provide

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<sup>74</sup> University College Hospital Archive, Rare Manuscripts Room, University College London (hereafter UCH Archive), General Committee, A1/2/1; Guy's Hospital, Greater London Records Office (hereafter Guy's Archive), Committee Papers, A3/9.

<sup>75</sup> The hospital set itself the task of training children's nurses: Hospital for Sick Children, Great Ormond Street (hereafter GOS Archive), Letters, GOS/8/151.

<sup>76</sup> GOS Archive, Board of Governors, GOS/1/6/1; Royal Chest Hospital archive, Greater London Records Office (hereafter RCH Archive), Annual Reports, A8/1.

the element of coordination that the Select Committee had recommended.<sup>77</sup> Equally, hospitals were moving towards closer cooperation with the foundation of the Central Hospital Council in which the major hospitals joined to discuss matters of mutual interest.<sup>78</sup>

To limit the field of study this thesis had focused on eight institutions, each indicative of their respective category: St.Bartholomew's, the London, Guy's, University College Hospital, the Hospital for Sick Children, the Royal Chest Hospital, the German Hospital, and the Whitechapel Infirmary. Additional material on other London and provincial hospitals has been drawn from contemporary and secondary sources to provide a more comprehensive overview of the metropolitan hospital system. Time and storage has damaged many hospital records. Where records exist, inadequate storage has made many unfit for consultation.<sup>79</sup> For specialist hospitals these problems are compounded by the sheer lack of information. The Hospital for Sick Children lacks patient records, but offers extensive administrative records; the Royal Chest Hospital, though it has substantial gaps in its records, equally provides a variety of sources. The Whitechapel Union was not included in the *Lancet's* investigation of workhouse infirmaries, but it has comprehensive records, especially for admissions. Selection has not been based solely on archival criteria as each hospital has its own merits. To provide an institutional background each hospital selected is discussed separately below.

For the *Daily Telegraph* in 1891 St.Bartholomew's was 'one of the richest, most reputed and oldest hospitals in England'. In the nineteenth century St.Bartholomew's was 'the principal hospital in the centre of London'; 'at least the equal of any other in the

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<sup>77</sup> Prochaska, *Philanthropy*, 22-73.

<sup>78</sup> These were: St.Bartholomew's, King's College Hospital, University College Hospital, Guy's, St.Thomas's, Charing Cross, the London, the Middlesex, the Royal Free, St.Mary's, and St.George's: St.Bartholomew's Archive, City & Hackney Archive, Smithfield (hereafter SBH Archive), Governors' Minutes, Ha/1/27.

<sup>79</sup> The records of the Hospital for Sick Children for instance were stored in a barn until the archive was founded, those of University College Hospital were found in the building's basement.

kingdom'.<sup>80</sup> This did not place St.Bartholomew's in the vanguard of reform or development. A candle contract was renewed until 1895 and the hospital's poor management provided a regular target for the medical press.<sup>81</sup> Income, derived primarily from land in London and therefore immune from the effects of the agricultural depression, never rivalled the income attributed to the London. However, St.Bartholomew's was regarded as the premier endowed hospital and until the First World War it functioned outside the benevolent economy.<sup>82</sup> Where St.Bartholomew's was unique for its financial position, the London was 'the largest general hospital in the United Kingdom'. In 1877 it had 790 beds but 'only touched the fringe' of illness and accident in the East End.<sup>83</sup> From 1872 accidents and acute cases dominated admissions, producing the distinctive position where the medical staff were entirely responsible for admissions in a period when the governors were encroaching on their control of the medical college. Size created peculiar administrative and financial problems that no other hospital in London experienced. Sydney Holland, the hospital's chairman and 'prince of beggars', described the financial position in 1896 as 'depressing', although in the previous year the hospital had an income of £61,916.<sup>84</sup>

Guy's was the last of the endowed hospitals. Building was started in 1721 using the gains of Thomas Guy's dealings in the South Sea Bubble, but it was endowed on his death in 1724 just as posthumous charity was moving out of fashion.<sup>85</sup> The hospital dovetailed neatly into the institutional expansion of the period initiated by the foundation

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<sup>80</sup> Cited in the SC on Metropolitan Hospitals, 1st Report, 171; SBH Archive, Governors' Minutes, Ha/1/23.

<sup>81</sup> SBH Archive, Governors' Minutes, Ha/1/27. In 1869 the *Lancet* launched an attack on the hospital which ran throughout the year, including the method of election and expenditure, describing the hospital as a 'closed corporation': *Lancet*, 2 (1869), 615.

<sup>82</sup> SBH Archive, General Account Books, Hb/23/3-4.

<sup>83</sup> Clark-Kennedy, *The London*, 71; SC on Metropolitan Hospitals, 1st Report, 123.

<sup>84</sup> Clark-Kennedy, *The London*, 129; for Holland see J.F.Gore, *Sydney Holland: Lord Knutsford, A Memoir* (1936), while N.Barnes, 'Dockers' Hospital' (Unpublished Bsc. Dissertation, Wellcome Institute Library, 1993) offers a more critical analysis of his work with the Poplar Hospital.

<sup>85</sup> 32nd Report of the Charity Commission, PP 1840 XXXII, 711.

of the Westminster in 1719. However, it drew inspiration from Thomas Guy's association with St. Thomas's which was the hospital's neighbour until the latter moved to Lambeth. As one of the few institutions south of the Thames, it exhibited particular demands on resources. A changed economic environment from the late-1870s onwards eroded endowed income and forced a series of financial innovations that altered the hospital's structure of finance. A conflict between the medical staff, governors and matron in 1880 generated a virtual state of civil war and a public scandal, changing the hospital's administration. Guy's is therefore an ideal example of the level of friction in the relationships within the hospital, and the innovative, often desperate, approaches which governors pursued to secure funds.

University College Hospital was the archetypal teaching hospital. Located in one of London's most fashionable and medically overcrowded districts, the hospital was opened in 1834 to provide clinical experience and training as an ancillary to a university medical education. Consequently, educational demands joined with the pressures of a general hospital. University College Hospital's educational role conflicted with available resources, explaining why the hospital was all too often in debt and survived on erratic legacies and deficit financing.

The Hospital for Sick Children combined specialism in patient type with general treatment in a climate initially prejudiced against specialism. Inspired by Dr Charles West and Dr Henry Bence Jones, the hospital set the pattern for many similar institutions, regularly expanding its own facilities and placing a continuous strain on the public's benevolence. This expansion can be seen both physically and administratively. A Drug Committee was formed in 1857 followed by a Finance Committee in 1858 and a House Committee in 1872, though clinical clerks were only appointed in 1886 along with a paid auditor.<sup>86</sup> The inspiration behind the hospital's foundation and its specialist nature gave its medical staff a more secure and influential position than at other hospitals. Conflict, however, was still apparent. Indeed West eventually dissociated himself from the hospital, publishing a scathing attack on the governors when they failed to carry out his nursing and administrative reforms.<sup>87</sup> The Royal Chest Hospital can also be defined as a specialist

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<sup>86</sup> GOS Archive, Committee of Management, GOS/1/2/6-18.

<sup>87</sup> GOS Archive, Committee of Management, GOS/1/2/15.

hospital, but adopted a different remit by treating one category of disease. Established as the 'Infirmery for Asthma, Consumption and Other Diseases of the Chest' in 1814 by Dr Isaac Buxton, the hospital witnessed substantial changes from 1850, not least to its name. In 1919 it finally became the Royal Chest Hospital, a change that marked half a century of continuous expansion. Parallels exist with the Hospital for Sick Children. The medical staff held a favoured position, but one not without friction. Increased pressure on physical resources promoted a need to expand capacity and services. The governors made strenuous efforts to restrict expenditure and aggressively pursued funds, capitalising on the hospital's proximity to the City and its character as it developed from a local to a metropolitan institution.

The German Hospital can be defined as an ethnic institution and was recognised as the leading medical institution for an immigrant community in England. Unlike the French Hospital it was not run as a mission, but as a voluntary hospital. Discussions had started in 1843 with the support of the King of Prussia and the British royal family, but it was not until 1845 that the hospital was officially opened in premises obtained in Dalston where the governors took over the Infant Orphan Asylum.<sup>88</sup> The hospital modelled itself on its English counterparts, though it admitted German speaking patients without a governor's recommendation. Its ethnic background was transcended from the start. Charity was solicited from the German community and from the German states, but the governors also encouraged local contributions and admitted English patients as outpatients under a governor's letter and, in exceptional circumstances, as inpatients. The governors administered their finances prudently, utilising the hospital's ethnic base and the surrounding area to stimulate collections so that Burdett could claim that it had the second highest proportion of income from philanthropy in London.<sup>89</sup> Development, however, was not without incident. A religious crisis in 1894 had a direct impact on the hospital's finances, while throughout its history the medical staff attempted to strengthen their position resulting in periodic conflict.

The Whitechapel Union existed outside this philanthropic sphere and provides an institutional comparison to the developments in the London hospitals. Created out of the

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<sup>88</sup> German Hospital 1850 Annual Report.

<sup>89</sup> Burdett, *Hospitals and Asylums*, 122.

larger Stepney Union and located in the East End amid sweated industry and abject poverty, it provides the ideal test case to review the expansion of Poor-law facilities and the inclusion of non-pauper patients within the Poor Law. The Whitechapel Union was regarded as a model union regularly cited in government reports. The guardians sought a symbiotic relationship with charity through its restrictive policy on outdoor relief, but they were not beyond obstinacy and resisted external influence where they felt that it conflicted with the local community's interests.<sup>90</sup>

#### 4. ANALYSING THE HOSPITAL

The institutional development of the medical institutions outlined above points to the complexity of changes and issues surrounding the experiences of London's hospitals in the nineteenth century. Within these institutions a period of change was in progress in which their structure of funding and administration was adapted, extended and developed. Voluntarism remained central to provision, but the gradual transformation of the hospital from a philanthropic to a medical institution imposed new pressures that gradually modified both the nature of charity within the hospital and the charitable nexus between the governors, doctors, nurses, patients and contributors.

To Victorians 'the financial difficulties of hospital administration' were 'matters of notoriety'.<sup>91</sup> Governors were preoccupied with the necessity of fundraising for an institution permanently over stretched by demand. This contemporary awareness has been neglected by historians. The Victorians' preoccupation with charitable income and their belief that hospitals were supported 'either wholly or in the main, by voluntary contributions' has persuaded historians to all too readily attribute the hospitals' income to charitable sources and interpret financial crisis as a symptom of managerial inefficiency and a failure to attract new sources of income.<sup>92</sup> This view has characterised Victorian hospitals as dependent on public support and sympathy through legacies, subscriptions and

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<sup>90</sup> Ryan, 'Politics and Relief', 146.

<sup>91</sup> SC on Metropolitan Hospitals, 1st Report, 15.

<sup>92</sup> *Times*, 16 August 1860, 8; N.Evans, "'The First Charity in Wales": Cardiff Infirmary and South Wales Society', *Welsh History Review*, 9 (1979), 332.

donations. These mechanisms of charity can be collectively labelled 'direct' philanthropy because in them the benevolent motive and choice of institution were most visible.<sup>93</sup> Legacies, subscriptions and donations were not the only means of charitable funding and Chapter 2 examines the different fundraising tactics hospital governors used.

Chapter 3 challenges the *a priori* assumption that all hospitals were funded by charity alone. In a society acutely embarrassed by poverty and disease, medicine was an important beneficiary of charity, but hospital finance was an exercise in balancing the books. Governors purposefully pursued money saving initiatives, developed non-charitable sources of income, and adopted active fundraising tactics. As one governor of the Royal Chest Hospital admitted, hospital income came from 'great and widely spread source[s]'.<sup>94</sup> Standard interpretations exclude many basic aspects of hospital income where diversity was the rule rather than the exception, and not all hospitals relied on philanthropy as the main source of their funding. Chapter 4 explains the development of hospital income within Rosenberg's framework to show how the hospital's financial structure was influenced by medical expansion, rebuilding and increased demand, but at the same time shaped by voluntarism and the nature of London's benevolent economy.<sup>95</sup>

Hospital finance could not remain static when the nature of the institution was changing, and at the same time the hospitals' administrative structure was equally undergoing a process of expansion and change. Chapter 5 explains the hospitals' administrative commitment to voluntarism through its managerial structure and social background of its governors and patients. It shows that an alteration of hospitals' financial base was not inextricably linked to developments in the hospitals' administration. Other factors were responsible for the development of the hospitals' internal administration. Changing social *mores* and attitudes to the nature and extent of poverty produced a steady decline in philanthropy's domination and in the hospital a contender for control emerged. Chapter 6 illustrates how an increasingly assertive medical profession attempted to realign the hospital to reflect medical and not moral standards. This is not to suggest that by the turn of the century that the medical staff were dominant.

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<sup>93</sup> See Appendix for a discussion of the classification of hospital income.

<sup>94</sup> RCH Archive, Annual Reports, A8/2.

<sup>95</sup> Rosenberg, *Care of Strangers*.

Rather, the authority of the non-medical staff was modified by the professionalisation of medicine and a change in the nature of the hospital. The non-medical staff's hegemony was eroded, but at best a dual administration was created in which power was frequently contested. Chapter 8 returns to the issue of hospital finance to consider how an apparent financial crisis from the 1880s onwards encouraged fears about state intervention. It highlights the boundaries between civil society and the state in healthcare and discusses how the Prince of Wales Hospital Fund and the Central Hospital Council were constructed as voluntary alternatives to state intervention.

By comparing the changes in the hospital to those in the Whitechapel Union in Chapter 7, these developments can be related to the wider nature of healthcare provision in London to see if they were a function of philanthropy or related to the institutional provision of medical care. The *Lancet's* inquiry into metropolitan workhouses in 1866 concluded that 'the State hospitals are in the workhouse wards'. Medical care for most of the sick poor was not provided by the voluntary hospitals, despite their prestige and concentration of services, but by the Poor-law infirmaries.<sup>96</sup> Hodgkinson believes that by 1871 infirmaries had become firmly established as the hospital branch of the Poor Law; the 1905-9 Royal Commission showed that they represented the specialist institutions that the original legislators of the 1834 Act had hoped to create, even if they had paid little

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<sup>96</sup> The Poor Law has been the subject of numerous studies at both national and regional level, though fewer studies look in detail at the nature of its medical services. The Webbs' study is a classic, but M.A.Crowther, *The Workhouse System 1834-1929* (1981) provides an excellent account, while A.Digby, *Pauper Palaces* (1978) still offers the best regional survey. Others like P.Wood, *Poverty and the Workhouse* (1989), discuss provision in relation to poverty and F.Driver, *Power and Pauperism: The Workhouse System 1834-1884* (Cambridge, 1993) looks at the historical geography of provision. R.Lambert, 'A Victorian National Health Service', *Historical Journal*, 5 (1964) sees vaccination providing the basis for a national health service, though few have followed his lead. Hodgkinson's *Origins of the National Health Service* outlines the development of Poor-law medical services, but looks at evolution from the viewpoint of the Poor-law medical officers. Her extensive survey ends in 1871 and includes little about London. Though P.Ryan, 'The Politics of Relief' in M.E.Rose (ed.), *The Poor and the City* (Leicester, 1985) analyses the East End, it is mainly in terms of the restrictions on outrelief and the COS's influence rather than on medical relief. G.Ayers, *England's First State Hospitals and the Metropolitan Asylums Board* (1971), does attempt to trace provisions under the MAB, but the main focus is on the hospitals for infectious diseases and the conflicts around their location.



attention initially to medical provision.<sup>97</sup> Poor-law medical services were hampered by the principle of less-eligibility and the restrictions of Gladstonian economics, but they evolved in parallel to the hospitals. Both provided medical relief for the sick poor, though Poor-law infirmaries customarily treated the more acute and chronic cases which hospitals generally refused to admit. An expansion of the Poor Law's services witnessed a broadening of financial support to avoid burdens on the sensitive poor rate. This was not so much a strategy, more a product of institutional growth. Infirmaries were also administered by non-medical staff, through the indirect authority of the central board and the Poor-law guardians. This again juxtaposes lay authority against an emergent medical profession within a similar matrix of financial diversification.

The *Tomlinson Report* showed that our own structure of healthcare now faces problems similar to those confronting London's hospitals at the end of the nineteenth century. Historically the metropolitan hospitals were an important part of a complicated benevolent economy in a period when the boundaries between civil society and the state were gradually being redefined and the roles of charity and taxation were beginning to be questioned. At the same time professional values were starting to erode the *mores* of the established elite. A study of the Victorian London hospitals' financial and administrative development illustrates these themes and helps explain the pressures acting on charity and the growth of institutional charitable provision. Hospital finance therefore provides a starting point to discuss the wider issues affecting the hospital's development, the nature of philanthropy and charitable contributions, and the process by which the medical profession sought to gain control over their institutional working environment. In doing so it locates the hospital within the broader context of voluntarism to explain the balance between charitable and non-charitable funding and authority in a charitable institution.

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<sup>97</sup> Hodgkinson, *Origins of the National Health Service*, 486.

## **Part I: Philanthropy and Funding**

## 2

### The Philanthropic Imperative

#### 1. DIFFERING DEFINITIONS

The voluntary ethic which underlined the hospitals' existence created an ideal that 'an Englishman rarely stands aside from public business' with an 'obligation to contribute, in one way or another to the common good'.<sup>1</sup> The proliferation of voluntary agencies that resulted in the mid-Victorian period allied itself with the assumption that the state should play a minimal role, leaving philanthropy, in cooperation with local government, to 'superintend most moral, charitable, education and welfare services'.<sup>2</sup> Where the reality of government action did not match this ideal and was gradually extended, charity was assigned and carried out a crucial role in the Victorian welfare system. There was scarcely 'a form of human want or wretchedness for which a special and appropriate provision [had] not been made'.<sup>3</sup> Benevolence remained ubiquitous, yet both immune from precise measurement and under constant scrutiny from the press and social commentators. With a self-conscious regard for public opinion, linked to an anxious concern for finance, philanthropists sought to relieve the social conditions that faced an increasingly industrialised and urbanised society. A latent antagonism to state intervention legitimised their reforming efforts. They believed that philanthropy presented a flexible solution to the problems facing society, but their activities helped readjust the boundaries between civil society and the state. Philanthropists revealed problems that were beyond the individual's competence, prompting calls for legislative activity as they pioneered 'recognition of new areas of concern but ultimately making it clear that voluntarism is not

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<sup>1</sup> D.Owen, *English Philanthropy 1660-1960* (Cambridge, Mass., 1964), 164.

<sup>2</sup> P.Thane, 'Government and Society in England and Wales 1750-1914' in F.M.L.Thompson (ed.), *Cambridge Social History of Britain 1750-1950*, 3 (Cambridge, 1990), 33.

<sup>3</sup> Anon, 'Charity: Noxious and Beneficent', *Westminster Review*, 3 (1853), 65.

enough'.<sup>4</sup> Charity, propelled by its own internal dynamic, came to lead welfare activities and the state followed.

Charity, however, is a contested concept. The word 'philanthropy' first appeared in 1625 in Misheu's *Guide to the Tongue*. It was believed to be derived from Greek where it meant 'a loving of man' and was first used by Bacon in 1625 in his essay on 'Goodness, and Goodness of Heart'.<sup>5</sup> Within the Victorian frame of reference it was largely understood in Christian terms and was widely eulogised in sermons and pamphlets as a Christian duty linked to sacrifice. Thomas Wentworth Higginson felt that charity was the noblest of epithets, but one that was not above suspicion or criticism.<sup>6</sup> The Victorians found no need to define the inspiration behind philanthropy. It was integral to their understanding of society and they remained confident that it would continue to ameliorate social problems. Historians have subsequently puzzled over the exact meaning of philanthropy. Contemporaries presented social, religious and philosophical rationales for benevolence, but made no effort to clarify the impetus behind charity. Some historians have gone as far as to assume that these motivations remain impossible to analyse, but this has not stopped their colleagues from constructing competing theories to explain the Victorians' benevolent actions.

Traditional interpretations of philanthropy have been rooted in a liberal, essentially Whiggish conception of history. Concentration, especially in Owen's work, focused on the endowed charities and the Charity Commission. Charity was shown to be progressive in an evolutionary model that culminated in the welfare state.<sup>7</sup> By the late 1970s a new critical approach had started to evolve. Marxist historians came to believe that industrialisation imposed pressure on communal and deferential patterns of authority, creating anxiety within the ruling elites. In response philanthropy became an instrument

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<sup>4</sup> B.Harrison *Peaceable Kingdom: Stability and Change in Modern Britain* (Oxford, 1982, 234.

<sup>5</sup> F.Bacon, *Goodness, and Goodness of Heart* (1625).

<sup>6</sup> T.W.Higginson, 'The Word Philanthropy' in *Freedom and Fellowship in Religion* (Boston, 1875), 330.

<sup>7</sup> See Owen, *Philanthropy*; W.Jordan, *Philanthropy in England 1460-1660* (1959); and B.Kirkman Gray, *A History of English Philanthropy* (1905).

of class domination; a means to assert Gramsci's idea of hegemony. In this view endowed charities were marginalised and the new nineteenth-century voluntary associations came to the fore, imposing a middle-class ideology onto society. Gareth Stedman Jones in *Outcast London*, wholeheartedly embraced such a social control interpretation and applied Mauss's anthropological construction of the 'gift relationship' to ideas of charity and power.<sup>8</sup> Attention was shifted to the activities of the Charitable Organisation Society (COS) and the modification of the 'gift relationship' as charity became more formal. The idea that philanthropy was a mechanism of power was not unique and had been discussed by Cobbett in 1816 and by Engels in his *Condition of the English Working Class*. Kidd amplified this interpretation, noting that many philanthropists worked with the conviction that they had an obligation to exert a moral influence on the needy.<sup>9</sup> Philanthropy as an instrument of social control was a seductive view. Garrard and Yeo acknowledged that voluntary associations were imperfect ideological transmitters, but Garrard himself noted that charity was crucial to the middle classes in their legitimisation of power.<sup>10</sup> Marxist historians, however, were not the only historians to reinterpret the role of charity. Prochaska equally redefined philanthropy, rejecting the Whiggish model of the passage to modernity. He repudiates the reductionist notion that charity was an instrument of social control and part of a middle-class conspiracy to inculcate its values onto a susceptible working class. Victorian charity for Prochaska was not inspired by the fear of social unrest, but by kindness. Benevolence in his interpretation became a positive concept, able to play an important role in society, mitigate social conditions and help expand the social role of women.<sup>11</sup>

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<sup>8</sup> G.Stedman Jones, *Outcast London: A Study of the Relationship Between Classes in Victorian Society* (1984) and M.Mauss, *The Gift* (1980).

<sup>9</sup> A.Kidd, 'Outcast Manchester: Voluntary Charity, Poor Relief and the Casual Poor 1860-1905' in A.Kidd & K.Roberts (eds.), *City, Class and Culture* (Manchester, 1985), 52.

<sup>10</sup> S.Yeo, *Religion and Voluntary Organisation in Crisis* (1979); J.Garrard, *Leadership and Power in Victorian Industrial Towns 1830-80* (Manchester, 1983).

<sup>11</sup> See F.K.Prochaska, *Woman and Philanthropy in Nineteenth Century England* (Oxford, 1980) and in *The Voluntary Impulse* (1988) Prochaska analyses philanthropy's continued contribution to the welfare state, a view shared by G.Finlayson, 'A Moving Frontier: Voluntarism and the State in British Social Welfare 1911-1949', *Twentieth Century British History*, 1 (1990).

In recent years there has been a move against such interpretations, as historians have returned to the pessimism of the earlier Marxist assumptions. Morris, in his study of the middle class and voluntary associations in early nineteenth-century Leeds, has become the main proponent of this view. He believes that voluntary societies were an important arena for middle-class activity, providing the framework through which they established their class identity. Morris admits that voluntary societies were not perfect transmitters of class values, but he sees them as providing an established cultural norm.<sup>12</sup> Trainor, in his analysis of the Black Country elites, notes that charity was modified by new public initiatives, but remained crucial to the elite provision of medicine and recreation.<sup>13</sup> For Trainor, it reinforced the 'benign use of middle class wealth, reduced points of conflict between middle class and working class people, helped channel the latter's aspirations as subscribers, and demonstrates the concerns of the upper orders for social problems'.<sup>14</sup> Others have followed his lead. Once more philanthropy has become a tool in class formation; an instrument of the middle classes to promote their hegemony.

Where does this leave the historian? Is philanthropy such a muddled idea that Jordan is correct in assuming that inspiration is 'immune... from the fumbling probing of the historian'?<sup>15</sup> True, Victorians did not leave detailed accounts of their motivations, but reconstruction is possible, synthesising the different historical approaches. In a study of hospital finance it is necessary to look at the philanthropic psyche through the workings of the hospital to understand how and why the Victorians gave. The vocabulary governors used in their fundraising indicate the impetus behind benevolence where the subscriber's own voice may be absent. Governors seemed to know instinctively what would motivate charity. No claim is made to present a complete picture, but to show what factors conspired to generate support for the London hospitals. In investigating the

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<sup>12</sup> R.J.Morris, *Class, Sect and Party: The Making of the British Middle Class, Leeds 1820-50* (1990).

<sup>13</sup> R.H.Trainor, *Black Country Elites: The Exercise of Authority in an Industrialised Area* (Oxford, 1993).

<sup>14</sup> Trainor, *Black Country Elites*, 351.

<sup>15</sup> Jordan, *Philanthropy*, 144.

motives for supporting one of the main channels of charitable action it can be hoped that some light is cast on the often conflicting reasons for benevolence.

## 2. MOTIVATIONS BEHIND HOSPITAL PHILANTHROPY

Metropolitan charity and support for London's hospitals was not the civic pride and social duty of the Manchester elite, the commercially inspired benevolence of Wakefield and Huddersfield, or the self-help of Oldham, but something more imprecise.<sup>16</sup> London's size, economic concerns and society, outlined in Chapter 1, combined with the sheer number of charities, many of which had a national significance, to create an amorphous voluntarism. Metropolitan charity was influenced by a variety of factors and had a vast array of institutional and personal outlets and this deprived it of a uniform image. It was shaped by the resources and attitudes of the high concentration of middle-class and professional occupations that the growth of London's service sector encouraged, though it would be unwise to rule out the importance of working-class philanthropy. The London middle class were not Gareth Stedman Jones's cynical supporters of the COS, but a diverse class with a strong faith in voluntarism.<sup>17</sup> No single charitable object had a uniform appeal and individuals were motivated by a wide range of concerns from guilt to gratitude.

Religion, particularly Evangelism, played a fundamental part in stimulating benevolence. Finlayson and Prochaska see religion as an important, though not sole motivation for philanthropy.<sup>18</sup> A religious and moral imperative dominated writing on charity and in the 750 works published on philanthropy between 1850 and 1898 Christian

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<sup>16</sup> See J.V.Pickstone, *Medicine and Industrial Society* (Manchester, 1985); H.Marland, *Medicine and Society in Wakefield and Huddersfield 1780-1879* (Cambridge, 1987); J.Foster, *Class Structure and the Industrial Revolution: Early Industrial Capitalism in Three English Towns* (1974).

<sup>17</sup> Stedman Jones, *Outcast London*, 241-315; for the COS see C.Mowat, *The Charity Organization Society 1869-1913* (1961); M.Rooff, *A Hundred Years of Family Welfare* (1972) or R.Humphreys, 'Poor Law and Charity: the Charity Organisation Society in the Provinces 1870-1890' (Unpublished PhD Thesis, University of London, 1991) for a more critical interpretation.

<sup>18</sup> Finlayson, *Citizen, State, and Social Welfare*, 47-49; Prochaska, *Voluntary Impulse*.

dogma remained prominent. Ministers rushed to publish their sermons on Christian charity, many finding inspiration in the life of Christ and the gospel of St. Paul. Some even claimed that philanthropy was the 'genius of Christianity', unquestionably belonging to the Church and an acceptance that benevolence was divinely inspired was common.<sup>19</sup> Philanthropy throughout the nineteenth century was idealised as a Christian virtue and was epitomised by the life of Christ and Christ-like love of mankind. To be charitable was to serve God as wealth was merely on loan from the divine saviour.<sup>20</sup> Even the hard-hearted COS, which sought to organise philanthropy and remove its pauperising and irrational sentimentality, subscribed to this view. It was felt that women were particular susceptible to this religious influence and such sentiments informed much of their benevolent activity.<sup>21</sup> The sterner faith of puritanism was modified as sympathy for suffering increased. In an environment that favoured an Evangelical approach to benevolence, action rested on a solid faith that philanthropy emanated from a sentiment of religious and personal sacrifice.

All religious denominations were actively involved in promoting charity, but it was the Evangelical revival at the end of the eighteenth century that was the most powerful catalyst for Christian charity. Evangelism provided 'a useful and timely ethic for the emerging middle class', rationalising worldly success as a product of providence and making it necessary to promote benevolence.<sup>22</sup> Conversion stood at the heart of Evangelism, and good works, though not essential to salvation, were seen as evidence of true conversion.<sup>23</sup> Evangelists therefore craved philanthropic employment to answer the spiritual anxiety that a preoccupation with sin generated. Charity was used by some philanthropists to resolve tensions within their personality, but Evangelists felt that they could not ignore the suffering of their neighbours, especially when their neighbours were

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<sup>19</sup> J. Horsford, *Philanthropy: The Genius of Christianity* (1862), vii.

<sup>20</sup> F. W. Farrar, *Social and Present-Day Questions* (1891), 96.

<sup>21</sup> See Prochaska, *Women and Philanthropy*.

<sup>22</sup> I. Bradley, *The Call to Seriousness: The Evangelical Impact on the Victorians* (1976), 145; 157.

<sup>23</sup> Bradley, *Call to Seriousness*, 21.



made in the image of God and had an immortal soul.<sup>24</sup> This conferred a duty to raise individuals out of their suffering so that they might be prepared to meet their saviour.<sup>25</sup> Charity in this context became God's will and merged with the Evangelists' overwhelming desire to reform the morals of their fellow men.

Evangelists were an important body of subscribers and philanthropic reformers, inspiring others to action; by 1850 an estimated three quarters of the country's charities were under their control.<sup>26</sup> William Wilberforce, best known for his anti-slavery campaigns, was a tireless philanthropist whose name appeared on the subscription list of some seventy charities.<sup>27</sup> At Guy's the administration was dominated by governors who came from an Evangelical background. The most prominent governors mirrored Wilberforce's enthusiasm for activity: Benjamin Harrison, the hospital's treasurer until 1876, supported 21 societies; Charles and Robert Barclay, prominent governors, supported 86 societies between them. Many, like Samuel Thornton and Charles Barclay, had known or worked with Wilberforce.<sup>28</sup> Evangelists were not just involved in the hospitals' administration. Flower and Letter Missions were Evangelists' attempts to humanise the hospital and increase contact with the sick poor.<sup>29</sup> Evangelists seemed to be everywhere, not least on the hospitals' subscription lists.

Charity, in a Christian framework, was regarded as its own reward, but the religious justification for benevolence was not completely disinterested. The Reverend Brook Lambert, writing in the *Contemporary Review*, saw the poor as a necessary evil designed by God to benefit the leisurely by giving them 'cases by which they might perfect themselves in spiritual medicine'.<sup>30</sup> Charity was projected as a means of buying

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<sup>24</sup> B.Harrison, 'Philanthropy and the Victorians', *Victorian Studies*, 9 (1966), 358; see Anon, *Charity: A Tract for the Times* (1874).

<sup>25</sup> S.Meacham. 'The Evangelical Inheritance', *Journal of British Studies*, 3 (1963/4), 92.

<sup>26</sup> K.Heasman, *Evangelicals in Action* (1962), 11.

<sup>27</sup> F.K.Brown, *Father to the Victorians: The Age of Wilberforce* (Cambridge, 1961), 71.

<sup>28</sup> Brown, *Father to the Victorians*, 355-357.

<sup>29</sup> Heasman, *Evangelicals in Action*, 225-231.

<sup>30</sup> Brooke Lambert, 'Charity: Its Aims and Means', *Contemporary Review*, 23 (1873), 463.

admission to heaven, an act of religious insurance for the afterlife. From this perspective Christian philanthropy could serve both the recipient and the giver, meeting humanitarian and selfish concerns under the general sanction of Christian theology. Administrators recognised this and regularly appealed to religious sentiments. Shaftesbury, speaking in favour of an appeal launched by the London Hospital in 1883, emphasised Londoner's religious duty to support the hospital.<sup>31</sup> The relationship was not entirely one-sided as hospitals fulfilled a need for the religiously motivated. Their explicitly humanitarian motive appeared to answer the spiritual and emotional poverty that had been generated by materialism.<sup>32</sup> However, it would be unwise to see Victorian charity as entirely the consequence of an Evangelical revival and religious sentimentality. Philanthropy was not simply, as the Evangelists would have it, the natural result of conversion or a product of a true acceptance of the Gospel. From the eighteenth century, according to Andrew, charity had moved from a pure expression of Christian devotion to acquire temporal characteristics.<sup>33</sup>

One contemporary wrote that the English are 'most devoted to sympathy and commiseration, most tenderly alive to the softest impression of every affection' and benevolence was a natural extension of this national characteristic.<sup>34</sup> The image of sickness was a compelling one that cut across social, political and religious boundaries. Governors carefully exploited such humanitarian sentiments and made 'piteous' appeals to public sympathy to alleviate the suffering of the sick.<sup>35</sup> A particularly emotive appeal was made by the Royal Chest Hospital in 1857 when it claimed that in treating diseases of the chest it was relieving a 'most fatal and distressing' form of illness.<sup>36</sup> The Royal Chest Hospital was, however, outdone by the Hospital for Sick Children. Emotive appeals

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<sup>31</sup> London Hospital Archive, College Library, Whitechapel (hereafter LH Archive), Public Meeting Minutes, A/10/8.

<sup>32</sup> M.Simey, *Charitable Effort in Liverpool* (Liverpool, 1951), 106.

<sup>33</sup> D.Andrew, *Philanthropy and Police: London Charity in the Eighteenth Century* (Oxford, 1989), 14-15; 18-22.

<sup>34</sup> J.Woodward, *To Do the Sick No Harm* (1974), 21.

<sup>35</sup> H.Davis, *Our Hospitals: Their Difficulties and Remedy* (1894).

<sup>36</sup> RCH Archive, Governors Minutes, A1/1.

were launched and books published like James Greenwood's *Little Bob in Hospital* in 1887, which explained the suffering of sick children and the hospital's good work in heart-rending terms. In 1858 the *London Journal* could write that 'there was no one with so many claims upon the sympathies of the benevolent' as the Hospital for Sick Children.<sup>37</sup> Only the most hard hearted could ignore such appeals. That the hospital attracted an increasing amount of revenue from philanthropy where other hospitals experienced a decline is indicative of its success in encouraging contributions.

Sympathy did not have to be impersonal. Often it was generated by a familial or personal experience of sickness. For example, William Henry Lueade, a long sufferer from gout and rheumatism, left a sum of money to St.Bartholomew's to treat the 'necessitous poor' with these complaints.<sup>38</sup> Neither did sympathy have to be based on emotional grounds. Hospitals stressed their poor financial position and hoped that a humanitarian spirit would motivate philanthropic support. Appeals were generally well rewarded, sometimes beyond the administrators' expectations. The governors of the London played on the fact that the hospital was 'the only large general hospital among the vast poor population in the East of London' and consequently faced considerable financial problems.<sup>39</sup> The governors warned that if charity was not forthcoming then money would have to be sought from the state, a threat that was directed at the hospital's supporters, not at the government. These appeals were invariably linked to claims to utility, and governors emphasised their institution's importance by using the number of patients admitted as an advertisement. Such claims for support motivated in some subscribers a personal attachment to their local institution. The German immigrant community had a natural sympathy for the German Hospital, as did the local community in Dalston who looked on the institution with pride. Personal association could work in a different way and familial or personal experience of a particular institution was a powerful generator of sympathy. Elizabeth Baly, who left money to St.Bartholomew's, did so because her

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<sup>37</sup> GOS Archive, Press Cuttings, GOS/8/153.

<sup>38</sup> SBH Archive, Legacy's Register, Hb/5/3.

<sup>39</sup> LH Archive, Scrapbook, A/26/31.

brother had been a physician there.<sup>40</sup> The reason for her bequest was not uncommon and was mirrored in other contributions. All hospital appeals built on an element of sympathy.

Where religion created a theological impetus for benevolence, wealth created its own responsibility. '*Noblesse oblige*', writes Finlayson, 'could merge into a way of quieting a conscience troubled by the possession of riches, or of justifying those riches by devoting a proportion of them to the benefits of others'.<sup>41</sup> Woodward notes that 'many a gambler and society miscreant found solace in channelling part of his ill-gotten gains to the cause of the sick poor'.<sup>42</sup> Guilt could be a powerful incentive to philanthropy, but hospitals reflected 'a tremendous sense of social duty and responsibility'.<sup>43</sup> In Manchester Pickstone claims that this was paramount in motivating contributions.<sup>44</sup> The traditional paternalistic ethos, which had been a persuasive doctrine in the early nineteenth century and, according to Joyce, a mechanism in industrial relations throughout the Victorian period, epitomised the social obligations of wealth.<sup>45</sup> Paternalists were hostile to organised benevolence, but their emphasis on the duties, rather than the rights of property and their stress on the role of the individual was a compelling argument in favour of charity.<sup>46</sup> In espousing, paternalism writers like Arthur Helps in his *Friends in Council*, earnestly stressed the social duties of wealth.<sup>47</sup> Novelists like Gaskell in *Mary Barton* (1848) and Dickens' *Hard Times* (1854) equally argued for greater social responsibility on behalf of the industrial bourgeois. Similar ideas were developed by Walter Rathbone in the 1860s. His book, *Social Duty*, expressed a widespread concern that the process of

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<sup>40</sup> SBH Archive, Legacy's Register, Hb/5/3.

<sup>41</sup> Finlayson, *Citizen, State and Welfare*, 49,

<sup>42</sup> Woodward, *To Do the Sick No Harm*, 19.

<sup>43</sup> B. Abel Smith, *The Hospitals 1800-1948* (1964), 5.

<sup>44</sup> Pickstone, *Medicine and Industrial Society*, 138-147.

<sup>45</sup> See P. Joyce, *Work, Society and Politics: The Culture of the Factory in Later Victorian England* (Hassocks, 1980), 90-170.

<sup>46</sup> D. Roberts, *Paternalism in Early Victorian England* (1979), 4.

<sup>47</sup> Roberts, *Paternalism*, 25.

industrialisation and urbanisation had produced a breakdown in cooperation between classes.<sup>48</sup> Rathbone called for a renewed 'intercourse between rich and poor' where charity was no longer a sentimental response, but the social duty of every man of wealth and leisure.<sup>49</sup> It was only through voluntary organisations that personal efforts could be fully utilised; only through personal energy and devotion that organised associations could mitigate existing evils. Both, it was anticipated, would ultimately serve to promote social harmony and moral reform.<sup>50</sup> Charity as a social duty was widely confirmed by other authors and it was acknowledged that the community had a great responsibility to support the local hospitals. For Robert Fowler, M.P., this represented a 'debt' that could only be repaid through contribution.<sup>51</sup>

T.H.Green's politics of conscience and the Idealist school of thought assimilated these ideas to give a new philosophy for philanthropic action. From the mid-nineteenth century Anglicanism faced a crisis in confidence and a forced transformation that allowed a new rationale for benevolence to emerge.<sup>52</sup> The gradual acknowledgment that Christian charity was based on emotion rather than on reasoning and championed causes without careful investigation, encouraged doubt about its vitality within the intellectual elite. This appeared to leave only 'vapid philanthropic sentiments' based on misunderstanding.<sup>53</sup> A theory and discipline were craved at a time when recurrent social crises from the 1860s onwards heralded a 'rediscovery of poverty' and a resurrection of the desire to bridge the

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<sup>48</sup> Rathbone was a Unitarian and active in providing charitable nursing care in Liverpool: Heasman, *Evangelicals in Action*, 285-6.

<sup>49</sup> Rathbone, *Social Duties*, 30.

<sup>50</sup> Rathbone, *Social Duties*, 67-90; 109.

<sup>51</sup> LH Archive, Scrapbook, A/26/31.

<sup>52</sup> A growing awareness of social inequality mixed with an increased desire to be free from 'puritan' restraints and a revulsion against orthodox theology made Anglicanism less dogmatic. It was an attempt to stem the perceived tide of secularism and falling attendance at congregations: see H.McLeod, *Class and Religion in the Late Victorian City* (1974).

<sup>53</sup> W.Houghton, *Victorian Frame of Mind* (1957), 275; Brown, *Father to the Victorians*, 318.

gap between classes.<sup>54</sup> The idea of atonement conferred an obligation to save others no longer seemed enough; a broader, less selfish secular faith was required to meet the widespread problems of urban society.

Green reinterpreted the Evangelicals' understanding of charity through his own theological perspective, merging it with paternalistic ideas and an emphasis on social duty to replace dogma, miracle and the Church with a doctrine of good works and altruism.<sup>55</sup> He moved away from the notion of benevolence as evidence of a true conversion and insurance for redemption and in so doing attempted to save Christianity by making it rational and defensible. Attention shifted from personal salvation in the next world to improving the condition of this one. The result was a surrogate faith, a new canon of altruism that produced a moral obligation to strive for improvement.<sup>56</sup> Green's ideas on charity, succinctly expressed in his *Prolegomena of Ethics*, provided a theoretical framework for conduct to those who were turning from religion to philosophy.<sup>57</sup> Philanthropy for him embodied the 'moral initiative' combined with a vivid sense of personal responsibility for social problems, which at its purest represented a denial of self that was at the heart of the true meaning of faith. Consequently, Green assigned benevolence an extraordinary role.<sup>58</sup> However, to produce the required moral development, charity had to be linked to an active participation in the life of the community in a rejection of possessive individualism.<sup>59</sup> Participation became the vehicle for reform where the active citizen would set a moral example for action, alleviating the

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<sup>54</sup> Kidd, 'Outcast Manchester', 49.

<sup>55</sup> M.Richter, *Politics of Conscience: T.H.Green and his Age* (1964); A.Milne, *The Social Philosophy of English Idealism* (1962), 19-30.

<sup>56</sup> Green developed his theory of obligation not from ideas of salvation, but from Jowett's teachings at Balliol College where Green had been an undergraduate and was to become a fellow. Jowett had guided his students to realise their own moral potentials, and Green developed this into a teleological theory for advance: Richter, *Politics of Conscience*, 198.

<sup>57</sup> S.Collini, *Public Moralists: Political Thought and Intellectual Life in Britain 1850-1930* (Oxford, 1991), 84.

<sup>58</sup> Richter, *Politics of Conscience*, 312.

<sup>59</sup> Richter, *Politics of Conscience*, 319.

need to change the urban and social environment.<sup>60</sup> Philanthropists had stressed the moral benefits of charity, but Green integrated this into a philosophy that made benevolent action dependent on personal service rooted in a sense of obligation. These ideas were epitomised in Mary Ward's novel *Robert Elsmere* which popularised Green's teachings and effectively symbolised the cult of altruism.<sup>61</sup>

Green became an apostle of a new conception of citizenship that gave a theory and a scheme of action for charity. However, he was part of a growing strand of Idealist thought that he had helped inspire.<sup>62</sup> Toynbee Hall and the settlement movement were practical attempts to put Green's ideas into practice and many of his students were among the most active settlers.<sup>63</sup> Founded in 1884 by Samuel Barnett, son of a Bristol manufacturer of iron bedsteads and vicar of St.Jude's, Whitechapel, Toynbee Hall was a lesson in civic Idealism. Barnett persuaded university men to join him by convincing them that work with the slum dwellers of the East End offered the best chance to discharge the social duty of their position in society and to assuage the guilt that this privileged position imposed, implementing Green's ideas on obligation, community service and personal association.<sup>64</sup> Other practical philanthropists, intellectuals and writers including Toynbee, Bosanquet and Caird developed and transmitted his teachings. Theorists like Benjamin Kidd echoed Green's ideas, building on the altruism of Christianity to evoke a sense of social duty that sacrificed individualism to the good of the community.<sup>65</sup> Hobhouse and Barnett adapted Green's active citizenship to advocate a system of limited state intervention, while Loch and Bosanquet from within the COS

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<sup>60</sup> J.Hobson, 'The Social Philosophy of Charity Organisation', *Contemporary Review*, 70 (1896), 723.

<sup>61</sup> Collini, *Public Moralists*, 81.

<sup>62</sup> S.Collini, 'Idealism and "Cambridge Idealism"', *Historical Journal*, 18 (1975), 175.

<sup>63</sup> See Meacham, *Toynbee Hall*; A.Briggs & A.Macartney, *Toynbee Hall* (1984); and A.Vincent & R.Plant, *Philosophy, Politics and Citizenship* (1984), 132-149.

<sup>64</sup> Vincent & Plant, *Philosophy, Politics and Citizenship*, 132.

<sup>65</sup> For Kidd's ideas see D.P.Crook, *Benjamin Kidd: Portrait of a Social Darwinist* (Cambridge, 1984).

infused Idealism with a strong sense of individualism.<sup>66</sup> Even Henry Sidgwick in his *Elements of Politics*, while recognising the state's responsibility for welfare, upheld an understanding of philanthropy that stressed active citizenship.<sup>67</sup> Often obscure and with a meaning not always clear or intelligible, Green

... appealed to the asceticism of an audience which had been brought up under Evangelical discipline. He rehabilitated the moral value of asceticism and thus denied the judgement of utilitarian hedonism, which dismissed self-denial as absurd survival of medievalism. And he made social service and reform into the moral obligation of the conscientious man.<sup>68</sup>

His ideas found resonance within the middle classes, building on their sense of guilt and their fears of a disintegration of society. Through active community service that worked towards a 'common good', philanthropists could hope to reestablish social harmony and solidarity, though Green still expected the recipients of charity to subscribe to the middle class values of thrift, self-help and filial piety.<sup>69</sup> What Green and the Idealists achieved was a new rationale for philanthropic action and a philosophical framework for reform and service, one, it was hoped, that would modify public envy and justify wealth.<sup>70</sup> Because of its highly theoretical and intellectual content Idealism could never replace religion's contribution to charity, but it did provide a new intellectual motivation for giving and influenced debates on welfare into the late 1930s.<sup>71</sup>

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<sup>66</sup> See A.M.McBriar, *An Edwardian Mixed Doubles: The Bosanquets versus the Webbs* (Oxford, 1987).

<sup>67</sup> M.Taylor, *Men Versus the State: Herbert Spencer and Late Victorian Individualism* (Oxford, 1992), 94-95.

<sup>68</sup> Richter, *Politics of Conscience*, 220.

<sup>69</sup> Though the 'common good' was central to Green's thinking and in accord with new liberalism's interpretation of social reform, he never offered a definition in terms of behaviour or legislation: M.Freeden, *The New Liberalism: An Ideology of Social Reform* (Oxford, 1978), 57.

<sup>70</sup> Hobson, 'Social Philosophy of Charity Organisation', 717.

<sup>71</sup> See J.Harris, 'Political Thought and the Welfare State 1870-1940: An Intellectual Framework for British Social Policy', *Past & Present*, 134-5 (1992).



A feeling of altruism, a sense of humanitarian sympathy, or religious sentiment, were not charity's only sources of inspiration. Even Anglo-Jewry, which had its own philanthropic tradition and strong sense of obligation to co-religionists, could not separate itself from secular concerns.<sup>72</sup> Less noble incentives were part of the morphological landscape of charity and governors were adept at manipulating them. Foucault has argued that hospitals were part of an institutional effort to establish normative standards.<sup>73</sup> Other historians have developed this view, placing the hospital within a wider discussion of philanthropy as an instrument of social control.<sup>74</sup> However, social control is a confused concept, supported more by hindsight than by evidence. It adopts a reductionist and mechanistic view of society, focusing on coercion and deviant behaviour, a conviction that takes Durkheim's notion of 'socialisation' to extremes. Social control is an idea that has been frequently misused and those who use it tend to generalise and place every action within some grand design. Even in sociology it has not had 'a very successful career'.<sup>75</sup> It is perhaps too much to argue that hospitals were part of a 'carceral archipelago' that produced a docile deviant population.<sup>76</sup>

There was an awareness that charity had a role to play in staving off social unrest by acting as 'a conspicuous symbol of the charitable impulses of the rich'.<sup>77</sup> Philanthropists like Shaftesbury and Barnardo shared this view, and the *Charity Record & Philanthropic News* commented that it helped 'crush out that class feeling which at times threatens to turn this England of ours into two hostile camps'.<sup>78</sup> Charity was stimulated at times of stress. In 1885-6 a harsh winter and worker demonstrations in the

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<sup>72</sup> See E.C.Black, *The Social Politics of Anglo-Jewry 1880-1980* (Oxford, 1988) especially chapter three.

<sup>73</sup> M.Foucault, *Discipline and Punishment* (1979).

<sup>74</sup> See A.Donajgrodzki (ed.), *Social Control in the Nineteenth Century* (1977) for the use of the social control theory in a wider historical context.

<sup>75</sup> Cited in C.K.Watkins, *Social Control* (1975), 2.

<sup>76</sup> C.Dandeker, *Surveillance, Power and Modernity* (Cambridge, 1990), 27.

<sup>77</sup> Marland, *Medicine and Society*, 140.

<sup>78</sup> *Charity Record & Philanthropic News*, 6 January 1881, 2.

West End in February 1886 saw a rush of charitable effort and the foundation of a special Mansion House Fund.<sup>79</sup> Hospital governors certainly expected gratitude and deference from patients. The religious ministrations of a resident chaplain and the controlling rules on behaviour can be seen as a vehicle for instilling a bourgeois ethic. One writer felt what was 'sown' in the hospital was liable to take root in society.<sup>80</sup> For the *Christian Times*

no child can have gone though [the Hospital for Sick Children] without having such a memory impressed upon its mind - a revelation of the great fact of charity, the great fact of devotion, the great fact that man lives not for self, but for God and his neighbours.<sup>81</sup>

In the northern industrial towns the hospital's practical benefits in the treatment of accident cases were made to serve an ideological purpose in the hospital's foundation and in their appeals for support. Local industrialists and factory owners used them to show that they cared for their workers as a balance to the exploitation of the factory system.<sup>82</sup> In London the situation was different. The difference can partly be attributed to the diverse nature of London's economy and to the public health problems that the capital generated. The governors of the London hospitals believed that they answered a practical social need rather than acted as a bulwark against revolution. Some supporters may have been motivated by a desire to control patients, but this was not the view of the majority. The hospital was not an ideal vehicle for control. According to Thompson, 'it seems that the intended recipients picked out what they wanted from the facilities on offer, and rejected the moral or authoritarian message'.<sup>83</sup> Rules were more easily made than enforced and supplication was a ready facade to secure treatment. More patients

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<sup>79</sup> Stedman Jones, *Outcast London*, 290-98.

<sup>80</sup> Anon, 'The Poor and the Hospital', *Fraser's Magazine*, 13 (1876), 723.

<sup>81</sup> Cited in GOS Archive, Press Cuttings, GOS/8/153.

<sup>82</sup> See Pickstone, *Medicine and Industrial Society*; Marland, *Medicine and Society*.

<sup>83</sup> F.M.L.Thompson, 'Social Control in Victorian England', *Economic History Review*, 34 (1981), 206.

discharged themselves than were removed by the governors and many of the rules reflected a shared system of social values.

A different perspective does show that subscribers supported hospitals for more selfish reasons. Some writers warned against selfish philanthropy, but the repugnance ascribed to it was insufficient to have any major influence on subscribers.<sup>84</sup> Governors were prepared to utilise these selfish concerns to elicit support. Hospitals, it was widely felt, offered 'the best guarantee that the money devoted to the purpose shall be judiciously expended'.<sup>85</sup> They were presented as an economical and effective use of charity. In a society increasingly concerned about the effectiveness of 'gratuitous' assistance, this was a powerful justification for support. The *Daily Telegraph* echoed these ideas in 1871, emphasising the benefits that hospitals presented to the subscribing public and to the nation:

We know that they [hospitals] assist in the case of accidents that may happen to anybody in any class, we know that as schools of medical science they are equally useful to the rich and poor, and we know that they repay the cost to the community over and over again, in sending back to their work and homes, in health, men who if they had not been so attended to, would probably have left families destitute upon the world.<sup>86</sup>

Contemporaries felt that it was impossible to 'accurately represent the service rendered to humanity' that hospitals provided.<sup>87</sup> Charles West wrote that the laws of political economy ensured that any contribution to charity would benefit society.<sup>88</sup> Hospitals therefore appealed to ideas of national efficiency. Sickness was seen as an important cause of poverty, plunging families into crisis and hardship. Hospitals, it was contended, removed a root cause of distress by rapid and effective treatment, while quick intervention

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<sup>84</sup> F. Peck, *The Uncharitableness of Inadequate Relief* (1879) on the hypocrisy of selfish charity.

<sup>85</sup> *Fraser's Magazine*, 13 (1876), 715.

<sup>86</sup> *Daily Telegraph*, 20 February 1871, 2.

<sup>87</sup> *Lancet*, 2 (1878), 23.

<sup>88</sup> *Examiner*, 7 July 1877, 848-9.

prevented the spread of disease. This served a dual purpose. Industry and the economy benefited from a reduction in the time lost through sickness as patients were returned to productivity and could continue to contribute to the 'national' good. Equally, charity and the Poor Law were spared the expense needed to support the families of the sick for prolonged periods of time. Hospitals were accordingly presented as 'an important agent against pauperism', reducing the general reliance on charitable relief.<sup>89</sup> In effect, support for the hospital was projected as a means of saving money, an idea that appealed to sentiments of local parsimony at a time when the poor rate was under pressure from an expanding metropolitan Poor Law. The governors of the Royal Chest Hospital used these concerns and claimed that many of its patients were able 'to resume their customary employ and support of themselves and their families'.<sup>90</sup> Similar arguments were constructed in favour of Poor-law medical relief. To the commercial classes the idea of utility and value for money in return for a modest subscription, had a powerful appeal. Marland, in her study of Wakefield and Huddersfield, believes that it was such practical concerns that motivated many subscribers.<sup>91</sup>

The calculating extended this view of utility and saw that hospitals accorded a direct benefit to society through 'the experience which they afford to the medical profession'.<sup>92</sup> In a society acutely worried about the extent of disease and fearful of contagion this is hardly surprising. Some writers stressed that hospitals benefited both the rich and the poor through their contribution to medical science. Others were more partisan. An anonymous writer in *Fraser's Magazine* claimed that the Hospital for Sick Children should be supported because it allowed the medical profession to gain 'that knowledge of special disease of infancy which might be applied to the benefit of the children of the rich'.<sup>93</sup> Lord Taunton felt that this was why many supported the

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<sup>89</sup> F.Oppert, *Hospitals, Infirmarys and Dispensaries* (1867), 47.

<sup>90</sup> RCH 1850 Annual Report.

<sup>91</sup> Marland, *Medicine and Society*, 130.

<sup>92</sup> R.Dawes, *The Evils of Indiscriminate Charity* (1856), 8.

<sup>93</sup> Anon, 'A Visit to the Hospital for Sick Children', *Fraser's Magazine*, 49 (1854), 63.

institution.<sup>94</sup> The governors of University College Hospital expressed the same idea in a more muted form. They asserted that the hospital was doing an ‘incalculable good’ which tended ‘to the advancement of science and the relief of human suffering’.<sup>95</sup> Appeals on these grounds were widespread and formed part of a common vocabulary to generate support.

In addition to these benefits, ‘the majority of subscribers’ still wanted ‘a show for their money’, and this ‘show’ helped ease the flow of benevolence. Voluntary contributions to the hospital fitted within a hierarchy of giving. Each contribution attracted a certain number of privileges and hospitals matched these against a graduated scale linked to the size, rather than the nature of the gift. At the top of the hierarchy were those entitled to become governors, allowing the contributor an active role in the hospital’s management. It was these governors, as discussed in Chapter 5, who shaped the hospital’s internal administration and policy. However, the main physical return on a subscriber’s contribution was the provision of a governor’s letter which allowed the recipient to admit a certain number of patients according to the size of their contribution. Essentially it was a scheme of incentives, and subscribers felt it was ‘natural’ that they should have a *quid pro quo* for their support. However, many used their letters indiscriminately, ‘often in favour of their own dependents, and to save their own pockets’. Contemporaries worried about how subscription rights were being used and one speaker at a Social Science Association conference in Birmingham in 1868 feared that hospitals had become ‘private institutions for the relief of subscribers’ nominees’.<sup>96</sup> The admission of servants was seen as a particular problem. Hospital reformers were not unaware of this and campaigned ardently for the abolition of the letter system. However, it was too deeply entrenched and although admissions were increasingly being realigned on a medical footing few hospitals apart from the London were prepared to abandon the system. Employers developed the exploitation of letters to a sophisticated level, contributing to the hospital instead of providing insurance for their employees. The COS claimed that employers who did this were invariably those who paid their workers low

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<sup>94</sup> *Times*, 16 May 1861, 8.

<sup>95</sup> UCH 1869 Annual Report.

<sup>96</sup> *Lancet*, 1 (1882), 407; *BMJ*, 2 (1868), 433.

wages, but a small subscription made good economic sense as it was cheaper than insurance.<sup>97</sup> Railway companies certainly contributed to hospitals along these lines, though they were not the only companies to do so. The New River Company gave five guineas in 1852 to the Royal Chest Hospital, because of 'the liability of their outdoor servants to diseases of the chest'.<sup>98</sup> It was an accepted, though condemned practice that companies would flagrantly abuse their subscription rights and governors did not protest too vehemently as money was at stake.

Contributions conferred other, more social benefits to subscribers. Philanthropy was highly fashionable in Victorian society. The *Porcupine* in 1861 noted that 'the most fashionable amusement of the present age is philanthropy.... No small number of these benevolent persons are philanthropists because it is the fashion to be so; because it brings them into passing contact with this bishop or that earl'.<sup>99</sup> The annual ceremonies of charitable organisations, which took place at the height of the Season, brought many into contact with the social elite. According to an acidic critic of charity in the *Westminster Review*, many subscriptions were largely dependent on the names attached.<sup>100</sup> Queen Victoria's patronage of leading hospitals was seen as a great benefit, endorsing the value of philanthropy and when royal favour was given the institution's charitable income increased.<sup>101</sup> The German Hospital had a high level of royal patronage that extended beyond England, a fact emphasised in its appeals. Royal patronage, however, was only part of the social snobbery that hospitals invoked. Prominent and fashionable members of civil society were invited to fundraising events to lend hospitals social *cachet* and their names were given all due prominence on subscription lists. Patronage by the social elite, as Cannadine argues, was widely seen as a necessary precondition for success in any

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<sup>97</sup> *Charity Organisation Reporter*, 4 April 1878, 68.

<sup>98</sup> RCH Archive, Governors' Minutes, A1/3.

<sup>99</sup> Cited in Simey, *Charitable Effort*, 56.

<sup>100</sup> Anon, 'Philanthropy of the Age and its Relation to Social Evils', *Westminster Review*, 35 (1869), 447.

<sup>101</sup> Prochaska's new work on the welfare monarchy assesses the effect that royal patronage had on charitable societies: *Times Literary Supplement*, 15 January 1993, 15.

charitable activity.<sup>102</sup> The governors of the London lamented the death of the Duke of Cambridge in 1850 in these terms, noting that they had lost a 'generous contributor to its funds' and a powerful and unwavering friend, 'whose benevolent influence has been the means of permanently increasing the income of this important charity'.<sup>103</sup> The German Hospital equally felt the loss, especially as the Duke had been instrumental in eliciting support among English subscribers.<sup>104</sup> Not all who were asked gave their support or time, but hospitals usually attracted enough prominent supporters to confirm their social standing and appeal to the snobbery of some of their contributors.

Socially, charity was an emblem of social prestige, tapping a latent desire among the wealthy and aspiring for kudos. Philanthropy played a status-giving and a status-maintaining role. Governors accordingly carefully acknowledged every contribution. When subscribers felt that their contribution had not been recognised, they complained vociferously. At the London, a member of the East End Tradesmen's Association objected to the hospital's 1888 report because the Association's support had not been sufficiently recognised.<sup>105</sup> Legacies also served to enhance prestige as a form of posthumous self-aggrandisement, perpetuating the subscriber's name. This was important for the childless. Scholarships, such as the Stanley prize at St.Bartholomew's, were a prime example of this. They served to remind the recipient and society of the founder's generosity.<sup>106</sup> Others used legacies as a memorial for departed relatives, prolonging their memory out of love or perhaps out of guilt, answering a need they could not express while the relative lived. The endowment of hospital beds, such as Carl Wilke's gift of £500 to the German Hospital to support a child's bed in memory of his son, invariably fulfilled this function.<sup>107</sup>

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<sup>102</sup> D.N.Cannadine, *Lords and Landlords: The Aristocracy and the Towns 1774-1967* (Leicester, 1980), 221-2.

<sup>103</sup> LH Archive, Court Minutes/A/2/9.,

<sup>104</sup> German Hospital 1851 Annual Report.

<sup>105</sup> LH Archive, Court Minutes, A/2/14.

<sup>106</sup> SBH Archive, Trusts Register, Hb/19.

<sup>107</sup> German Hospital Archive, City & Hackney Archive, St.Bartholomew's (hereafter GH Archive), Hospital Committee, A/2/7.

To these 'selfish' concerns must be added contributions that were given from a feeling of gratitude. Governors were occasionally rewarded with a donation from a patient. Invariably the contributions were small, but they served an important ideological role, highlighting the hospital's contribution to provident and deferential habits, and much was made of them. One patient at University College Hospital wrote that she 'desires to forward... a donation of £5 5s as a small acknowledgement of the benefits she has received, and of her gratitude to all who have ministered to her'; another at the Royal Chest Hospital offered to renovate the hospital's brass plate 'as a token of his gratitude for the benefit received...'.<sup>108</sup> Not all were in a position to give, but many expressed a feeling of gratitude. One patient thanked the hospital for the treatment given to her daughter, but regretted 'that my position will not allow me a more substantial recognition than this'.<sup>109</sup> These were exactly the type of patient that hospitals and philanthropists aspired to help.

Where does this leave us? Support for hospitals did not embody every concern that could motivate benevolent action. Where they made an appeal to public and private sympathy, it was not particularly seen as a bulwark against social revolution. Contribution to medical charities might have highlighted a concern for the sick poor that ameliorated class tensions, but few hospitals in London made appeals to these sentiments. They preferred to play on religious sentiment, humanitarianism and the hospitals' social utility, appealing simultaneously to the selfish or altruistic concerns of their subscribers. All sections of society responded, but no individual did so from a single motive. Religion may have provided a strong context for inspiration, but the philanthropic psyche contained a conflicting mix of motivations that could be both altruistic and intrinsically selfish. Perhaps by playing on all these concerns hospitals ensured that their support was guaranteed, even if their demands eventually outstripped the charitable resources that were available.

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<sup>108</sup> RCH Archive, Governors' Minutes, A1/2.

<sup>109</sup> UCH 1884 Annual Report



### 3. PHILANTHROPY AND FUNDRAISING: WAYS OF GIVING

The motivations behind philanthropy were expressed through the contributor's voluntary gift. Governors invested time and effort in fundraising and a large part of the hospitals' administration, as illustrated in Chapter 5, was geared to finance. Sole responsibility rested with the governors and doctors assumed a marginal role in the hospitals' financial affairs. Income from charity dominated their concerns and it was to philanthropy that they turned to first to solve their hospital's economic problems.

Benevolence took many forms, but donations, subscriptions and legacies in the form of a cash gift were the traditional ways to contribute.<sup>110</sup> Donations could fluctuate wildly from year-to-year and legacies were unpredictable, providing a form of 'windfall' philanthropy that could not be relied on. Subscriptions, however, were without the same uncertainties. Subscriptions were small annual contributions, usually one guinea, and though in theory any amount could be contributed few gave more than five guineas. Colonel Makins, speaking at the Royal Chest Hospital's 1884 annual dinner, estimated that hospitals lost 8-10% of their subscribers annually through death.<sup>111</sup> Although this could take a heavy toll on income, the number of subscribers still tended to increase. Every effort was made to collect them, but as one philanthropist noted, 'the constant struggle of getting annual subscriptions is the one bit of weariness in hospital work'.<sup>112</sup> To ease this workload charitable organisations generally employed a paid collector who took a commission on the total raised. After 1896 collectors could use a printed directory, *The Charitable Ten Thousand*, to locate potential subscribers and they frequently crossed each other's paths in the pursuit of funds.<sup>113</sup> Cases of fraud were occasionally reported and Labouchere's *Truth* made a speciality of exposing charity swindles, but collectors had a monetary interest in ensuring that subscriptions were collected promptly and not allowed to lapse. At the German Hospital the collector, Mr Ostermoor, was required to visit the

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<sup>110</sup> The importance of these different charitable components are discussed in Chapter 3 where they are put in the context of the hospitals' structure of income.

<sup>111</sup> *Charity Record & Philanthropic News*, 4 (1884), 83.

<sup>112</sup> *Charity Record & Philanthropic News*, 17 (1897), 142.

<sup>113</sup> Owen, *Philanthropy*, 480.

‘mercantile and manufacturing towns’, but few were expected to travel outside London and many carried out their work in the hospitals’ immediate locality.<sup>114</sup> Governors were keen to build up a large body of subscribers and they attached considerable importance to them, but their fundraising efforts went far beyond this. Voluntary organisations, as Morris notes, rarely existed on subscriptions alone.<sup>115</sup> Hospitals perhaps more than any other type of benevolent society, tried to attract philanthropy through a variety of channels.

The benevolent often found it easier to make a donation than the long-term commitment that subscribing entailed. To encourage donations hospital governors awarded life or honorary governorships and subscribers’ privileges. At the Hospital for Sick Children, life governorships were given for any donation over £31 10s, and between 1850 and 1890 1,115 were granted.<sup>116</sup> No contribution was seen as too small and amounts varied considerably. Some like Baron de Hirsch, a Jewish financier and a member of the Marlborough House set, were major benefactors. In 1893 he gave £28,000 he had won on the ‘turf’ to the London hospitals; the Hospital for Sick Children alone received £1,200.<sup>117</sup> Others gave what they could afford and, unlike subscriptions, there was no set amount. All donations were acknowledged with enthusiasm, from the £7 7s received by the London from the workmen employed at Tebbutt & Company, to the £10,000 given by Sir John Blundell Maple in 1896 to help rebuild University College Hospital.<sup>118</sup> Major donations of this kind were invariably used to fund building and provided the financial foundation of several institutions, mostly outside London.<sup>119</sup> Large contributions of this kind were, however, rare and when they were received they were acknowledged with a greater show of publicity.

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<sup>114</sup> GH Archive, Hospital Committee, A/2/2.

<sup>115</sup> Morris, *Class, Sect and Party*, 298.

<sup>116</sup> GOS Archive, List of Life Governors, GOS/6/1/1.

<sup>117</sup> *Hospital*, 21 January 1893, 266.

<sup>118</sup> LH Archive, House Committee, A/5/29; UCH Archive, General Committee, A1/2/8.

<sup>119</sup> See J.R.B. Taylor, *Hospital and Asylum Architecture in England 1840-1914: Buildings for Health Care* (1991), 34-35.

Donations were not limited to money. Hospitals did receive contributions of land and stock, such as James Bentley's gift of £1,000 in 3% consols to St.Bartholomew's in 1857, but donations of this sort were infrequent. Donations of land created administrative problems and gifts of this kind were either invested, or more regularly sold in times of hardship.<sup>120</sup> Other types of non-monetary gifts were more frequent. The Hospital for Sick Children was particularly fortunate and received a large number of gifts, especially of toys and children's clothes. For example, in 1852 Charles West donated both his library and a hot-air bath; the following year Mr Jeggs gave a collection of toys and Mrs Latham some flannel dressing gowns.<sup>121</sup> All hospitals regularly received gifts of flowers and paintings. Many were given for reasons similar to those expressed by Lord Kirkaldie in his present of flowers to Guy's in 1875, 'for the decoration of the Hospital Wards'.<sup>122</sup> The royal household donated food, especially pheasants, and old linen, presumably for bandages, and doctors gave books and medical equipment to the hospitals where they had trained or worked. However, not all gifts were useful. The value to patients of a selection of tickets for the Princess, Globe and Shaftesbury Theatres given to the Royal Chest Hospital in 1896 must be doubted, though presumably the hospital's governors ensured that they were not wasted.<sup>123</sup> The *Hospital* in 1892 tells of a lady who gave 'several favoured institutions' a 'whole shopful of harmoniums', but rightly believed that many hospitals 'prefer[red] the simplicity of cash gifts'.<sup>124</sup> Governors wholeheartedly agreed. Non-monetary donations were an important factor in making hospitals a more pleasing environment, but governors attached greater importance to contributions of a more conventional nature.

Legacies were the most unpredictable source of charitable income, as shown by the amounts left to St.Bartholomew's:

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<sup>120</sup> SBH Archive, Legacies Register, Hb/5/3.

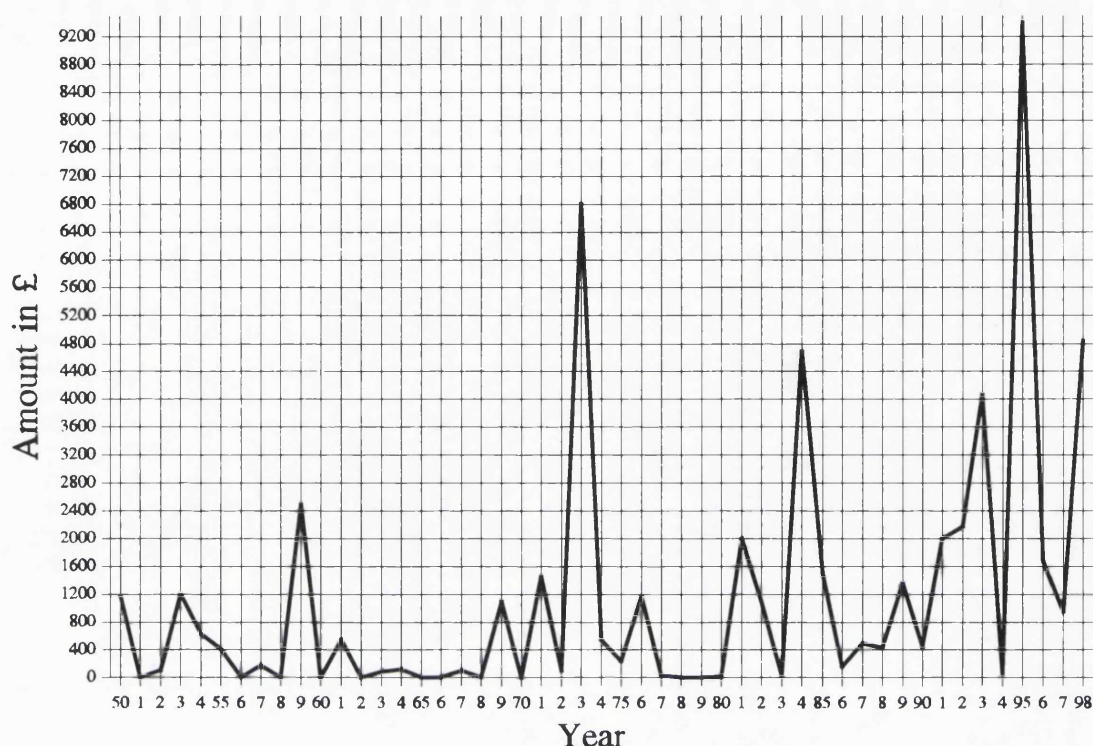
<sup>121</sup> GOS Archive, Committee of Management, GOS/1/2/3-4.

<sup>122</sup> Guy's Archive, Court Minutes, A3/10.

<sup>123</sup> RCH Archive, House Committee, A4/5.

<sup>124</sup> *Hospital*, 6 February 1892, 226.

Figure 2.1: St.Bartholomew's Legacies Received 1850-1898.



Source: SBH Archive, General Account Books, Hb/5/3-4.

Thomas Guy's endowment of Guy's encouraged a distrust of posthumous benevolence that was never entirely shaken. The 1736 Mortmain Act was the legal codification of this suspicion, strengthening testators' rights to overrule wills that left land in perpetuity to a charitable cause. Hardwicke, Lord Chief Justice in 1736, noted that the Act was designed to prevent individuals from giving money in perpetuity when they had not given during their lifetime, to ward against the 'locking-up' of land, and to prevent families from being disinherited. According to Andrew, this distrust of perpetual bequests had come to permeate the ethos of giving by the end of the eighteenth century.<sup>125</sup> Victorian observers felt that the Act had been introduced to prevent the Church owning the entire country.<sup>126</sup> A series of legal decisions under Lord Eldon's Chancellorship strengthened the testators'

<sup>125</sup> Andrew, *Philanthropy*, 46-47

<sup>126</sup> J.B., *Observations on Endowments* (1852), 2.

position.<sup>127</sup> The Mortmain Act was modified in 1881 and 1891, but the desire to ensure that land was not 'locked-up' was maintained. The *Standard* did note in 1890 that only one in seven testators left bequests, and most of those had no children.<sup>128</sup> A survey conducted by the *Daily Telegraph* in the following year found that only 13% of all legacies went directly to charitable cause, though the proportion among women was higher.<sup>129</sup> Most large wills, however, included some provision for philanthropy. Gifts in perpetuity were avoided; the aim was to assist the institution in the present by a cash gift which avoided all legal constraints.

The amounts left differed considerably. Between 1884 and 1898 the London received 660 legacies ranging from five guineas to an estate worth £119,423 from James Holden in 1894.<sup>130</sup> Invariably bequests were given with no clear purpose in mind, but some benefactors placed conditions on their bequests. Lueade's legacy to St.Bartholomew's mentioned above, or Jacob Gorfende's gift of £100 to the London in 1867 for the care of Jewish patients are two examples.<sup>131</sup> However, where a clear purpose was stated it was usually in favour of the provision of aftercare through the hospital's Samaritan Fund or its convalescent home. Samaritan Funds depended on this source of funding. Governors did their best to attract legacies and frequently fought legal battles over contested wills: the governors at Guy's were even known to apply directly to the recently bereaved for funds. All bequests were dutifully acknowledged as governors sought to display the hospital's good fortune in the hope that other benefactors would follow. They were at pains, however, to avoid the impression that their hospital was a rich endowed institution for fear of discouraging charity. The poor wording of many bequests ensured that hospitals did not receive all the legacies they were entitled to, but in general the benevolent public favoured them.

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<sup>127</sup> See I.Williams, *The Alms Trade* (1989), 22-25.

<sup>128</sup> Cited in *Lancet*, 1 (1890), 922.

<sup>129</sup> Owen, *Philanthropy*, 470-1.

<sup>130</sup> LH Archive, Legacy Book, F/9/3-4.

<sup>131</sup> LH Archive, Legacy Book, F/9/3.

The endowment of beds combined all these ways of giving. The arrangement was pioneered by the Hospital for Sick Children. In 1868 a collection of £1,000 raised by *Aunt Judy Magazine* was awarded to the hospital. At the request of the magazine's editor, Miss Gatty, the money was 'invested' to support a bed and in recognition the governors named it the '*Aunt Judy Magazine cot*'. Others quickly followed. It was decided to set the cost of endowing a bed at £1,000. Annual donations of £100 were accepted and in 1881 the first cot was funded by subscription; most were created by bequest. In all, between 1870 and 1900 74 cots were endowed, the majority after 1890, while 14 were funded by subscription.<sup>132</sup> With the addition of the 'Guildford Cot' in 1872 and the obvious success of the scheme, the *BMJ* recommended that other hospitals should follow the Hospital for Sick Children's lead.<sup>133</sup> The practice was quickly adopted because it provided a guaranteed annual income and an attraction for large gifts. Guy's, because of its reliance on rental income, was one of the last major hospitals to adopt the practice and only in 1894 were two beds and one cot endowed.<sup>134</sup> The German Hospital, in contrast, refused to endow beds. When approached by the Woolwich German Catholic Club in 1867, the governors pointedly dismissed the suggestion, explaining that the hospital was a 'free' institution.<sup>135</sup> Other hospitals, in urgent need of funds, could not afford to be so dogmatic and the endowment of beds became a common practice.

Subscriptions, donations and legacies were the traditional ways of collecting money from the benevolent public. However, to these must be added the 'endless variations and complications' of charitable funding.<sup>136</sup> Hospitals could not wait for philanthropists to favour them, so several active ways were employed to encourage benevolence. 'In order to stimulate the flow of funds', explained the *Medical Times & Gazette* in 1852, 'the charitable public is called upon to dine, to act, and to pray'.<sup>137</sup> One invention followed

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<sup>132</sup> GOS Archive, Register of Special Cots, GOS/6/1/25-7.

<sup>133</sup> *BMJ*, 1 (1872), 617.

<sup>134</sup> Guy's Archive, Treasurer's Report, A94/1.

<sup>135</sup> GH Archive, Board of Household Management, A/8/5.

<sup>136</sup> *Quarterly Review*, 177 (1893), 466.

<sup>137</sup> *Medical Times & Gazette*, 26 (1852), 39.

another and new devices were introduced mixing seriousness with entertainment. The *Charity Record & Philanthropic News* sardonically described charity's tactics as an 'amateur circus'. However, 'even the oldest and most meritorious of our philanthropic institutions would find itself completely neglected were it not continually to remind the public of its existence, either by festival, personal appeal, or effective advertisement'.<sup>138</sup> The *Hospital* disliked the fact that charitable organisations had to 'peg away' at benevolence, but many realised that despite the undignified nature of 'begging', it was often the only way to raise money.<sup>139</sup> It was believed that specialist hospitals had particularly aggressive fundraising tactics, but all hospitals survived by 'pleading in competition'.<sup>140</sup> Although the rattling of boxes on street corners was viewed as undesirable and reminiscent of the worst excesses of street musicians, hospitals tried every money-raising tactic possible. The North West London Hospital, however, broke the law when it organised a 'Prize Distribution' in 1890. The fundraising initiative, though highly successful and able to collect £1,500 in its first few weeks, was designated a lottery and declared technically illegal under the Lotteries Act. The governors, to avoid prosecution, were forced to return all the contributions.<sup>141</sup>

The pressure to contribute was unrelenting. 'It came from the pulpit and the platform, the reports and pamphlets of the charity societies, the numerous family and women's magazines' and especially from the press.<sup>142</sup> *The Times* devoted whole pages to advertisements from charitable societies and specialist journals were founded, like the *Charity Record & Philanthropic Review* or *Charity*, which reflected charity's incessant advertising. Hospitals were keen advertisers and gradually developed more sophisticated methods. Both the London and the East London Hospital for Children incorporated the message 'Supported by Voluntary Contributions' into the facade to remind passers-by of

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<sup>138</sup> *Charity Record & Philanthropic News*, 2 (1882), 104.

<sup>139</sup> *Hospital*, 6 February 1892, 226.

<sup>140</sup> *BMJ*, 1 (1892), 345.

<sup>141</sup> *Charity*, January 1890, 205.

<sup>142</sup> Prochaska, *Women and Philanthropy*, 39.

the hospitals' charitable status.<sup>143</sup> Governors at the Royal Chest Hospital were aware 'that publicity should be given to the charity': by the 1870s they were spending some 6% of the hospital's expenditure on advertising, and by the 1890s adverts were placed in 15 different papers and journals at once.<sup>144</sup> The aim was to reach the largest possible audience. Not all campaigns met with approval, but the most common complaint was the frequency of adverts: 'day by day a column and a half of the most urgent advertisements assure the public that, unless immediate aid is given, half [the] wards must be shut up'.<sup>145</sup>

Hospitals extended their appeal beyond the press. Governors issued pamphlets with photographs showing pleasant wards, flowers and nurses to increase their hospital's public appeal. The effect was to multiply patient admissions and strain finances further. The Hospital for Sick Children was particularly good at this form of advertising. Dickens added his influential support shortly after the hospital opened in 1852 with his 'Darling Buds' in which he forcefully argued for the necessity of a children's hospital in London and recommended the Hospital for Sick Children to the public.<sup>146</sup> Others soon followed. Greenwood's *Little Bob in Hospital* or Tom Hood's *Lilliput Lodgers* explained the good work of the hospital in the most emotive terms.<sup>147</sup> In 1892 *Suffering London* appeared, a rare example of cooperation between London's hospitals. Burdett had persuaded a meeting of hospital secretaries in November 1891 that they should cooperate and produce a book to publicise the work and plight of the capital's hospitals. It was made possible by a grant of £500 from the Scientific Press, but it made little impact on the financial problems facing the London hospitals.<sup>148</sup>

The main purpose of publicity was to announce the hospital's financial needs and their public appeals. Appeals were launched at public meetings where the first collection was made and promises of support were received amid much publicity. They allowed

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<sup>143</sup> Taylor, *Hospital and Asylum Architecture*, 34.

<sup>144</sup> RCH Archive, Finance Committee, A5/2.

<sup>145</sup> *BMJ* (1860), 458.

<sup>146</sup> J.Kosky, *Mutual Friends* (1989), 4.

<sup>147</sup> GOS Archive, Specimen Appeals, GOS/14/18.

<sup>148</sup> *Hospital*, 30 April 1892, 70.



hospitals to raise large amounts of income in a relatively short time. *The Times* was impressed when the London collected £24,000 in a matter of months in 1860, but the hospital had a long history of using appeals to generate much needed capital and was well suited to such efforts.<sup>149</sup> Appeals were often used to solve a particular financial problem or raise money for rebuilding. When Guy's faced a financial crisis in the early 1880s, the governors launched a public appeal amid much publicity in 1886. Every effort was made to collect the largest amount possible and the governors used their connections to raise money. Messrs Louis Cohen and Messrs Bristowe Brothers purposefully went round the Stock Exchange collecting money and £256 4s was collected from Lloyds.<sup>150</sup> Within four months £56,000 had been raised.<sup>151</sup> At the Royal Chest Hospital in 1891, after an uneasy start in October, an appeal brought in new subscribers 'almost daily' and by December £100 had been collected from this source.<sup>152</sup> Few hospitals were as regular in their appeals as the London. The governors, worried that debt was becoming a constant feature of the hospital's finances, sought to circumvent the problem by founding a quinquennial appeal in 1878, legitimising a large funding drive every five years.<sup>153</sup> The move proved successful and each new appeal was widely supported.

Debt was recognised as an excellent opportunity for launching an appeal, a realisation shared by the NSPCC.<sup>154</sup> Guy's stressed its financial position in its 1886 appeal and responsibility was transferred away from their financial management, on which many observers blamed the hospital's problems, to the effect the agricultural depression had on the value of their landed estates and on their income.<sup>155</sup> More cynical observers felt that governors were deliberately irresponsible in their financial management in the

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<sup>149</sup> *Times*, 7 May 1860, 9; London Hospital 1850 Annual Report, 8.

<sup>150</sup> Guy's Archive, Appeals Cash Book, D45/1.

<sup>151</sup> *BMJ*, 1 (1887), 739.

<sup>152</sup> *Charity Record*, 11 (1891), 393.

<sup>153</sup> LH Archive, House Committee, A/5/38.

<sup>154</sup> G.K.Behlmer, *Child Abuse and Moral Reform in England 1870-1908* (Stanford, 1982), 142.

<sup>155</sup> Guy's Archive, Appeals Cash Book, D45/1.

hope that their financial plight would motivate more contributions. Patient numbers were paraded as each hospital attempted to display its public utility in quantitative terms. Often this led to the deliberate manipulation of statistics to produce the most favourable image.<sup>156</sup> Frequently this backfired and patients were not unknown to die immediately after being discharged, resulting in scandals that greatly affected income. By mixing what they understood motivated contributions, governors ensured that all interests were appealed to and that money was always forthcoming.

The regularity of appeals became a distressing feature of hospital finance in London, matching the incessant charitable activity in other cities which tried the patience of the public.<sup>157</sup> Governors nevertheless continued to launch appeals because help was always forthcoming to their 'pathetic' pleas for support.<sup>158</sup> By the late 1860s only three of the twelve general hospitals did not have to make continuous calls on the public.<sup>159</sup> A further spate of appeals in the early 1880s created concern that the charitable nexus of hospital funding was beginning to break down. Under these conditions philanthropists began to fear that the state might have to intervene to prevent the widespread closure of beds. Governors used this fear to encourage the subscribing public to make further contributions, drawing on the hostility civil society felt towards the extension of state intervention and the faith in minimal government.<sup>160</sup>

Appeals were limited by their very nature. Governors could not constantly launch appeals for fear that they would antagonise the public and discourage contributions. To maintain an annual influx of charitable contributions hospitals organised annual dinner or balls. Philanthropists, as Prochaska observes, tried to make the act of giving a pleasurable occupation and the annual dinner was a successful format.<sup>161</sup> From the foundation of the

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<sup>156</sup> Abel Smith, *The Hospitals*, 39-40.

<sup>157</sup> N.Evans, 'Urbanisation, Elite Attitudes and Philanthropy: Cardiff 1850-1914', *International Review of Social History*, 27 (1982), 308.

<sup>158</sup> *Nursing Record*, 5 March 1898, 199 on the London's 1898 appeal.

<sup>159</sup> *Lancet*, 2 (1866), 730.

<sup>160</sup> See Chapter 8.

<sup>161</sup> Prochaska, *Voluntary Impulse*, 47.

voluntary hospitals in the eighteenth century, governors had held an annual dinner and they became the focus of the hospital's year, both socially and financially. St.Bartholomew's, as an endowed hospital did not have to attract philanthropy, but it continued to hold periodic dinners. Like the voluntary hospitals, St.Bartholomew's dinners had an inherent fundraising aspect. They were seen as 'a well chosen opportunity' to enable 'many of the Tenants to learn the vast amount of good which the punctual payment of rents ensured to the Poor Patients'.<sup>162</sup> The *Charity Record & Philanthropic Messenger* understood that dinners were often the only way to persuade more reluctant supporters to contribute, but not all journals were entirely sympathetic. *Charity* carried a scurrilous attack on how these dinners often degenerated into an excuse for social snobbery, gluttony and false appeals.<sup>163</sup> Dinners were seen as a burden 'on the time and patience of public men', but their highly successful nature made them impossible to abandon.<sup>164</sup> The governors at the German Hospital reflected a widespread opinion when they noted that without the annual dinner and the influx of donations this brought, they would not have been able to meet the hospital's 'liabilities'.<sup>165</sup>

The dinner was an important occasion that demanded long and careful planning, and invariably a special subcommittee was formed to relieve the main managing body of the work. Governors were anxious that everything should go to plan as the event reflected on the hospital. When the governors of the London felt they had been treated badly by the Hotel Cecil in 1868 they demanded a three-shilling reduction per head.<sup>166</sup> Planning was meticulous and expensive. At the Royal Chest Hospital the 1883 dinner cost £481 to organise, but the cost was worth it as it raised a total of £4,384.<sup>167</sup> Many hotels and meeting rooms offered hospitals special deals as a successful event often

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<sup>162</sup> SBH Archive, Governors' Minutes, Ha/1/22.

<sup>163</sup> *Charity Record & Philanthropic Messenger*, June 1868, 138; *Charity*, April/May 1891, 285-7.

<sup>164</sup> *Times*, 9 June 1868, 12.

<sup>165</sup> German Hospital 1858 Annual Report.

<sup>166</sup> LH Archive, House Committee, A/5/34.

<sup>167</sup> RCH Archive, Finance Committee, A1/5.

brought the hospital back to the same venue year after year. To meet some of the initial organisational costs tickets were sold and guests were invited to attend. University College Hospital, for example, sold tickets in 1897 for a guinea a head; the only free invitations went to 'various newspapers' for publicity purposes.<sup>168</sup> Prominent members of civil society were invited to speak, and governors initially aimed high before dropping their sights until a speaker was found. Lord Shaftesbury and the Prince of Wales regularly had to decline invitations because of the sheer number of dinners they were invited to. Speakers were called upon to praise the crown, the country, the army, and the hospital. They were followed by rousing speeches made by the hospital's governors and doctors that praised the institution's good work and lamented its financial difficulties. Once the annual report and the financial statement had been read, thanks were given to the hospital's medical staff, and finally the 'plate' was passed round. The intention was to motivate a captive and well wined and dined audience to new heights of generosity. The annual dinner became an institution that was carefully manipulated for funding purposes.

Church sermons on a hospital's behalf were a more sombre and thoughtful means of raising money. The foundation of the Metropolitan Hospital Sunday Fund in 1873 (see below) served to reduce the number of hospital sermons, but church collections for individual hospitals continued. Church collections were eagerly solicited and governors tried to persuade prominent bishops to preach on the hospitals' behalf and local clergy were constantly reminded of their duties to the local hospital. The London in 1869 wrote to 'all the clergy of the neighbourhood' to remind them that they should give 'an Annual Sermon on behalf of the London Hospital'.<sup>169</sup> At a local level hospital sermons became a regular, even annual feature of the local community, but the amounts collected were invariably small. The largest amount raised by a sermon for University College Hospital was £100 11s 9d in 1852 at St.Pancras Church, but most collections were rarely over £20.<sup>170</sup>

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<sup>168</sup> UCH Archive, Subcommittee Minutes, A1/5/3.

<sup>169</sup> LH Archive, House Committee, A/5/34.

<sup>170</sup> UCH 1897 Annual Report, 47.



THE CHARITY SERMON.

*Pol.* "MA, LET ME HAVE SIXPENCE, TO PUT IN THE POOL."

Source: *Punch*, 4 April 1868, 144.

Variations existed on these active forms of fundraising. Entertainments became a popular form of raising money. Philanthropists put on musical programmes, recitals and plays for the hospital and gave the profits as a donation. Organisation and responsibility remained with the hospital's supporters and governors preferred to keep their distance. When the governors of the Royal Chest Hospital accepted an offer from an amateur dramatics club for their fundraising programme of performances, they did so only on the proviso that it would involve no additional cost to the hospital.<sup>171</sup> It was a realistic request as one play for the German Hospital in 1887 made a loss of £20 which the governors were asked to meet.<sup>172</sup> The nature of entertainments varied widely and most were of an amateur nature. University College Hospital benefited from a play, a recital and a concert held on its behalf in 1883 alone, while Guy's welcomed the £130 raised by

<sup>171</sup> RCH Archive, Governors' Minutes, A1/5.

<sup>172</sup> GH Archive, House Committee, A/2/8.

the Anomalies Amateur Dramatics Club in 1896.<sup>173</sup> Not all offers were accepted. Governors at the German Hospital resisted any attempt to hold an event in their name after 1887, and the governors of the Hospital for Sick Children disapproved of amateur dramatic performances and preferred the more professional offer of the West End play 'Sweepstake' in 1891.<sup>174</sup> These rebuffs did not discourage philanthropists, as there was always one hospital that was glad to accept any money raised by these means.

The most innovative and widely criticised form of active fundraising was the charity bazaar. The model for the charity bazaars was the commercial bazaar that had become popular in the 1820s as an urban variant on the rural market.<sup>175</sup> The number of charity bazaars increased as the urban population grew and competition developed as each voluntary association eagerly sought new fundraising activities. Popularity and fashion were not enough to prevent the bazaars from being criticised and ridiculed. Churches warned of 'a vigorous inconsiderate benevolence, which is not indeed benevolence, but only a more specious form of selfishness', while organisers of commercial bazaars saw them as unfair competition and an attack on their livelihoods.<sup>176</sup> Hospitals ignored these slights and energetically embraced the bazaar as part of their fundraising activities; even the godly had to admit that 'large sums are frequently raised by these means'.<sup>177</sup>

Bazaars fitted within the practice of active fundraising and fulfilled subscribers' desires 'to have something to show for [their] money'.<sup>178</sup> The benevolent were encouraged to donate a wide range of gifts and then attend the bazaar to buy articles of a similar nature. In some cases an internal economy was created and goods purchased at one bazaar were given to another. Subcommittees that had been formed to organise dinners were converted into bazaar committees and their accumulated experience was

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<sup>173</sup> UCH Archive, House & Finance Committee, A1/3/3; Guy's Archive, Committee Papers, A3/11.

<sup>174</sup> GOS Archive, Press Cuttings, GOS/8/153.

<sup>175</sup> F.K.Prochaska, 'Charity Bazaars in Nineteenth Century England', *Journal of British Studies*, 16 (1976-77), 63.

<sup>176</sup> Cited in Prochaska, 'Charity Bazaars', 81-83.

<sup>177</sup> Cited in Prochaska, 'Charity Bazaars', 84.

<sup>178</sup> *Hospital*, 17 August 1895, 349.



A Charity Bazaar:



transferred into this new flexible fundraising format. Bazaars capitalised on their entertainment value, synthesising duty with shopping, so that in Robert Louis Stevenson's words they gave 'a direct and emphatic sense of gain'. It was an ideal entertainment for the leisured classes and organisers spared no effort in devising new attractions to create a carnival atmosphere, 'to make the exercise of charity entertaining in itself'.<sup>179</sup> *Cornhill Magazine* described a typical bazaar in 1861:

the bazaar is held in a large marquee which is surrounded by stalls and gaily decked out with ribbons, wreaths and flags, and covered with merchandise; and numberless young ladies preside at the stalls, dressed in the height of fashion, and never cease to attract public attention to the goods with the most winning, coaxing, insinuating, and, if one may be allowed the expression, wheedling ways.<sup>180</sup>

The German Hospital held its first bazaar in 1848. Dignitaries were invited from Germany and England and the items that were put on sale were collected through donations from across Europe. A subcommittee had been formed in 1846 to plan the bazaar, but the work strained the hospital's management resources and a special ladies committee had to be appointed in 1847 to help in the final arrangements. The bazaar, initially scheduled for 1847, was postponed until 1848 because the distress in Ireland aroused fears that money might not be forthcoming.<sup>181</sup> The governors' meticulous organisation was not unusual, though the scope of the hospital's European appeal was indicative of the institution's ethnic character. Planning was beset with problems and often frustrated by unforeseen obstacles, but in later years the hospital's bazaars were arranged with greater speed as experience was accumulated. University College Hospital's bazaar in 1886, after three decades of experience, took only four months to organise, though the Bazaar committee met nearly every week.<sup>182</sup> Plans quickly escalated. To the 135 foot run of stalls draped in yellow and white and banners proclaiming 'Success

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<sup>179</sup> R.L.Stevenson, *Charity Bazaar: An Allegorical Dialogue* (1868).

<sup>180</sup> *Cornhill Magazine*, 4 (1861), 339

<sup>181</sup> GH Archive, Bazaar Committee, Ha/68/2/1.

<sup>182</sup> UCH Archive, Subcommittee Minutes, A1/5/1.



to the University Hospital', marionettes, a Punch and Judy show, fortune tellers, light refreshments, artistic performances by the College's Amateur Dramatics Society, and a fish pond were added. Police were placed inside and outside to maintain order, though the entrance fee of five shillings on the first two days ensured that only the most respectable gained admission.<sup>183</sup> The governors of the German Hospital felt that such an atmosphere was unwise and solo performers were rejected as 'they would too greatly attract the attention of the public and consequently stop the progress of the sale'.<sup>184</sup> Bazaars were after all designed to raise money, not solely to provide charitable entertainment, as this was merely a means to an end.

The financial rewards were invariably worth the organisational effort: in 1898 the London's Press Bazaar added some £12,000 to the hospital's ailing funds and the German Hospital's 1867 bazaar was important in removing the debt that had burdened the institution since rebuilding.<sup>185</sup> In combining commerce with amusement, charity bazaars were popular, fashionable and highly profitable. More time was devoted to the organisation of these bazaars than to the hospitals' day-to-day management and in comparison the arrangements for the annual dinner seemed trivial. Royal and aristocratic patronage gave these events a patina of respectability and provided an important attraction in themselves. Strenuous efforts were made to have a member of the aristocracy open the bazaar, though for London hospitals, with their high profile and aristocratic support, this was less of a problem than for smaller charities. At the German Hospital this was utilised to the full and personal contacts created a network of support that extended across Europe. However, the organisation and publicity needed ensured that though bazaars were a regular and increasing feature of the benevolent economy, for individual institutions they remained a periodic spectacle. Given philanthropy's competitive nature, it was often easier to organise a charitable ball or dinner for the appeal could be directed to existing supporters, leaving bazaars as an important but infrequent source of funding.

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<sup>183</sup> UCH Archive, Subcommittee Minutes, A1/5/1: Five shillings seems to have been a standard entrance fee for bazaars, helping to maximise the hospitals' income even if nothing was bought, though this was difficult in itself as 'customers' were assailed from every quarter and stall holders were not above a certain element of dishonesty.

<sup>184</sup> GH Archive, Bazaar Committee, A/Ha/68/2/2.

<sup>185</sup> LH Archive, House Committee, A/5/47.

Collections provided a more frequent source of charitable income. Governors aimed to stimulate collections by placing collection boxes in the hospital and throughout London. Boxes in outpatients' departments generated much interest as it was believed that they reflected contributions from the grateful and deserving poor. By 1888 the Royal Chest Hospital had some 1,027 boxes in London, but they raised little money.<sup>186</sup> Outside the hospital, individuals arranged collections and plates were passed around at meetings and Mrs Gladstone even extended this to her breakfast parties. Most were on a more organised basis. Although governors did not adopt the door-to-door techniques of the Bible Society, they did try to encourage collections, especially at a local level. Contemporaries disapproved of noisy street collections, but the governors of the Royal Chest Hospital had no qualms in taking money collected in the local public houses.<sup>187</sup>

The London and University College Hospital attempted to organise these collections on a systematic basis. Unlike the Metropolitan Hospital Sunday Fund and Metropolitan Hospital Saturday Fund (discussed below), these collections were highly localised and limited to the support of one hospital. The first systematic collection scheme was started in 1868 in Whitechapel to aid the London. In April, an independent organisation called the People's Five Shillings Subscription Fund started to make inquiries about the admissions' rights that could be given to 'small' subscribers. The governors agreed to allow three outpatient admissions for every annual subscription of one guinea from the organisation.<sup>188</sup> The Fund aimed to allow those 'who may come to the Hospital for Medical or Surgical aid' to 'subscribe directly through their Firms or their Clubs to the maintenance of the Institution' and it set about organising collections in the surrounding factories and firms and among local working-class organisations.<sup>189</sup> The People's Subscription Fund became a semi-autonomous body with an organisation separate from the hospital, though the governors paid the collector 25 shillings per week.<sup>190</sup> At

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<sup>186</sup> RCH Archive, Finance Committee, A5/1.

<sup>187</sup> RCH Archive, Finance Committee, A5/1.

<sup>188</sup> LH Archive, House Committee, A/5/34.

<sup>189</sup> London Hospital 1899 Annual Report, 12.

<sup>190</sup> LH Archive, House Committee, A/5/35.

first the amounts raised were small, but after 1878 the Fund's contributions began to increase, mirroring the rising popularity and success of the Saturday Fund. The governors, however, found the work of the Fund 'satisfactory' and made few references to it in their minutes, though they did acknowledge its support in their annual reports.

University College Hospital developed a similar scheme in 1877, but here the governors and chiefly Nixon, the hospital's secretary, retained the guiding influence. Nixon's recommendations to the governors in November 1877 presented the scheme as one that would encourage self-help, allowing workers to contribute towards the cost of their own future medical care.<sup>191</sup> The People's Contribution Fund aimed to facilitate the 'appointment of annual and life governors amongst the tradesmen and the working classes, in order to place in their own hands the facilities for obtaining hospital treatment'. It also hoped to 'increase the annual income of the charity, by creating an interest in the prosperity of the hospital amongst those for whose benefit it is intended'.<sup>192</sup> An altruistic rhetoric did not conceal a desire to reduce social tension. The intention behind the Fund was purely financial, an opportunity carefully controlled by the governors to raise money from the working classes that did not offend the subscription rights of middle-class supporters. Local groups under middle-class leadership were set up throughout London to stimulate working-class contributions and collection boxes were widely distributed. No contribution was too small and the Fund proved highly successful. Attempts to organise such schemes at a metropolitan level produced a new type of giving that partially redefined the role of individual benevolence.

The foundation of the Metropolitan Hospital Sunday Fund in 1873 signified a new departure in hospital funding, establishing the first in a series of benevolent funds that culminated in the Prince of Wales Hospital Fund.<sup>193</sup> The Sunday Fund set the pattern for others to follow. Of these the Saturday Fund proved the most successful, rivalling the Sunday Fund; others like the Football Fund never progressed beyond the planning stage. Together they represented the most innovative source of hospital funding and a new form of benevolence through 'indirect' philanthropy, where the individual ceded the right to

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<sup>191</sup> UCH Archive, General Committee, A1/2/4.

<sup>192</sup> *BMJ*, 1 (1880), 903.

<sup>193</sup> For a discussion of the Prince of Wales Hospital Fund see Chapter 8.

control the destination of the gift to an investigating organisation. The work of the Saturday Fund is discussed in the following chapter along with the funds' financial contribution to the London hospitals, but to illustrate the aims and ambitions behind the benevolent funds the Sunday Fund is explained here.

The Sunday Fund was not unique as it fitted within an existing pattern of charitable societies and provincial collecting schemes. Despite the rival claims of the unknown Mr Henn, the movement was inspired by Thomas Barber Wright's actions in Birmingham.<sup>194</sup> As proprietor of the *Midland Counties Herald* he used the paper to launch a public fund in 1859 to aid the Birmingham General Hospital.<sup>195</sup> Wright's scheme was pioneering in that he subtly changed the nature and intention of the appeal. The idea was simple: one Sunday a year was to be set aside to collect money from every place of worship in the locality. The income raised would then be distributed according to the 'needs and merits' of the local medical charities.<sup>196</sup> Sympathetic clergy had traditionally dedicated church collections to individual hospitals, but under a fund these contributions were redirected away from a single institution to an organisation that coordinated sermons, universalised support, and redistributed collections as a solution to the medical charities' perceived financial difficulties. The pulpit was coopted to preach the gospel of hospital funding, systematically publicising medical relief to motivate benevolence. It was envisaged that a fund would encourage reform, as distribution was to be placed in the hands of a scrutinising committee that would identify any problems and penalise hospitals accordingly. Hospitals, it was hoped, would reform, if only to improve the size of their awards.

James Wakley, as editor of the *Lancet*, recognised in the Birmingham scheme a system through which the hospitals' endemic financial crisis could be resolved within a framework that encouraged a wider reforming imperative. From 1869 he called for the national extension of the Birmingham movement, stressing the moral benefits of community action and the practical advantages of ensuring that hospitals remained adequately funded. Donations to such a fund, it was argued, removed the sick poor from

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<sup>194</sup> *Hospital*, 13 October 1894, 33.

<sup>195</sup> *Hospital*, 17 November 1888, 99.

<sup>196</sup> Owen, *Philanthropy*, 485.

those 'permanently chargeable on the poor rates' by guaranteeing effective hospital treatment and a quick return to work, playing on one of the hospital's main attractions.<sup>197</sup> Wakley's agitation initially had no immediate impact in London, but spurred further provincial collections. When representatives from the London hospitals finally met they were uncertain and inclined to believe that a fund would 'lead to a falling-off in annual subscriptions and dinner collections'.<sup>198</sup> Hospitals jealously guarded their independence and it was on these grounds that University College Hospital refused to send a representative to the first conference to discuss a metropolitan fund in 1870.<sup>199</sup> No governor was prepared to propose a plan that would potentially benefit another institution over his own.

It was widely doubted that Christianity could make such a firm commitment when London faced spiritual destitution. An increased awareness of social inequality, a growing desire to be free from puritan restraints, and a revulsion against orthodox theology were prompting a transformation in religion. Simultaneously, there was a fall in the size of congregations and many felt that the church itself needed reforming before religion could help the hospital.<sup>200</sup> However, congregations did offer their support, whether enthusiastically or not, and in doing so ensured the Sunday Fund's success. This can be explained by the moves churches and chapels made to secularise their appeal. They moved into the community and reoriented recreation on moral grounds, through leisure activities, clubs and associations in which the religious meaning was subverted by the need to hold the congregation together, as shown by Yeo in his study of Reading.<sup>201</sup> The Sunday Fund was part of this attempt to place organised religion on a new and popular footing. Church and chapel benefited by associating themselves with practical benevolence in an 'irreverent age' and the Fund acted as an additional means of involving the church in the neighbourhood while upholding the sanctity of the sabbath for the good

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<sup>197</sup> *Lancet*, 2 (1869), 781.

<sup>198</sup> *Lancet*, 1 (1872), 624.

<sup>199</sup> UCH Archive, General Committee, A1/2/3.

<sup>200</sup> H. McLeod, *Class and Religion in the Late Victorian City* (1974), 285.

<sup>201</sup> See Yeo, *Religion and Voluntary Organisation in Crisis* and B. Harrison, 'Religion and Recreation in Nineteenth Century England', *Past and Present*, 38 (1967).

of the community.<sup>202</sup> It replaced the active citizen's initiative with a church-sponsored charity.

The Fund served another purpose for church and chapel. According to Kent, Anglicanism was moving towards a common identity with other religious institutions.<sup>203</sup> The Fund could be projected by more enlightened ministers as a means of establishing interdenominational cooperation to counter the heated debates within Christianity that threatened the social power of religion. Benevolent societies such as the British and Foreign Bible Society had been used to create a consensus for religious cooperation, but charity to the sick poor had a wider appeal.<sup>204</sup> It was uncomplicated, fitted within established Christian doctrines, and was easy to support. By common association in a benevolent fund without political connotations and sympathetic to all denominations, cooperation could be seen as an attempt to jettison differences and provide a modicum of ecumenical collaboration against one of society's more pressing problems.

How much these views influenced the participating congregations is uncertain. Sir Sydney Waterlow, then Lord Mayor of London, treasurer of St.Bartholomew's and major philanthropist, certainly believed that part of the motivation behind the Fund was to 'help people to believe that, though there were religious differences, they had still a common ground of action and a common object which all might promote'.<sup>205</sup> Waterlow was ideally placed to express this conviction.<sup>206</sup> Wakley provided the journalistic support, but it was Waterlow who overcame hospitals' practical opposition and established the movement in London.

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<sup>202</sup> *Hospital*, 21 January 1893, 260.

<sup>203</sup> J.Kent, 'The Role of Religion in the Cultural Structure of the Late Victorian City', *Transactions of the Royal Historical Society*, 23 (1973), 159; R.Currie, *Methodism Divided* (1968), 176-85.

<sup>204</sup> See R.H.Martin, *Evangelicals United: Ecumenical Stirrings in Pre-Victorian Britain 1795-1830* (1983).

<sup>205</sup> *Times*, 17 January 1873, 8; Morris, *Class, Sect and Party* argues that voluntary organisations served as a class unifier and even when divided on religious grounds they created parallel organisations which provided common experiences.

<sup>206</sup> See G.Smalley, *The Life of Sir Sydney H Waterlow* (1909) for an account of Waterlow's life.

It was not until November 1872 that a meeting of hospital representatives was convened. This established a provisional committee to test the practicality of found a fund in London. By this point a consensus had started to develop as governors became aware that their increasingly insecure economic position was not a temporary phenomenon. Waterlow's view that the movement 'had not heard a single objection against it' was, however, clearly erroneous.<sup>207</sup> Considerable animosity surrounded these early efforts and Waterlow worked tirelessly to organise an administration committee, which was finally established in January 1873. The provisional committee's discussions and Waterlow's control established in advance the basic organisational principles. Hospital governors were consulted, but much to the *BMJ*'s annoyance the medical profession was excluded, a reflection of doctors' marginal role in the debate over hospital funding. The members of the committee, who were among London's leading financiers, businessmen, politicians and philanthropists ensured that organisation was on strict commercial grounds. 250 invitations were issued to the clergy for a conference on 16 January 1873 to launch the Fund and on the Reverend Dr Brook's suggestion each minister was asked to invite a layman to avoid clerical dominance.<sup>208</sup> The conference was a success and endorsed all of the provisional committee's plans, reappointing it as a management committee to organise the first collection.<sup>209</sup> A few West End parishes complained that the administrative task was too large, while other parishes feared for their general collections and the Bishop of London made last minute recommendations to postpone the collection until the following year. The Fund, however, had already set the date for the first collection and was determined not to make any alterations.<sup>210</sup>

The first collection was not as impressive as the organisers had envisaged, raising £27,700, a sum far below the *Spectator*'s estimate of £80,000. The result was nevertheless heralded as a triumph. *The Times* congratulated the Fund, but the *Lancet* was disappointed. It continued to campaign ardently for the movement, establishing a special

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<sup>207</sup> *Times*, 11 January 1873, 6.

<sup>208</sup> *Times*, 11 January 1873, 6.

<sup>209</sup> *Times*, 17 January 1873, 8.

<sup>210</sup> *Lancet*, 1 (1873), 280.

supplement in 1886 to publicise the Fund, but the anticipated collection of £50,000 per annum proved elusive, and the journal periodically lamented that more could not be achieved. Other contemporaries were more caustic. Critics saw in the Fund a challenge to the role of the active citizen and predicted that as a result the hospitals' charitable resources would fall. To discredit the movement, the *Saturday Review* called it 'bastard benevolence', allowing contributors to ease their conscience while giving no thought to the object, and claimed that its managers were an 'irresponsible body of administrators'.<sup>211</sup> The *Charity Record & Philanthropic News* proved a constant antagonist. It believed that the Sunday Fund produced no real benefit and deemed it a 'failure', despite publishing contradictory statements.<sup>212</sup> Antagonism partly stemmed from the fact that the journal was a firm supporter of the Fund's competitor, the Saturday Fund, and although it was sympathetic to the Sunday Fund's intentions, nothing the Fund did met with its approval.

By 1881 criticisms had largely abated. Subscriptions and donations had not fallen as feared but continued to rise. For hospitals, as long as the administration and expenditure kept within pre-defined boundaries, a grant was almost guaranteed. The Sunday Fund universalised support and the *Lancet* believed that it transcended the 'exclusive care of the wealthy and aristocratic classes of society'.<sup>213</sup> The fact that the Fund could be projected as a solution to social tensions was a useful by-product that was not part of the original founders' intentions. However, it was used to improve the Fund's status. In effect the Sunday Fund had succeeded in making hospitals more visible to the public and became 'one of the most important sources of income that many of the London hospitals possess'.<sup>214</sup> It allowed a greater number to contribute, but removed the traditional benefits of subscription. This is perhaps why indirect philanthropy was never able to replace direct philanthropy's financial contribution. Many subscribers wanted more than a feeling that they had helped the sick poor and the Fund failed to offer

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<sup>211</sup> Cited in the *Lancet*, 1 (1873), 882.

<sup>212</sup> *Charity Record & Philanthropic News*, 7 (1887), 120; 8 (1888), 200.

<sup>213</sup> *Lancet*, 2 (1882), 126.

<sup>214</sup> *Lancet*, 1 (1896), 1613.



individual subscribers' rights though it extended a limited number of letters to congregations.

The stimulants to charity, the balls, the bazaars and even the Sunday Funds, were designed to raise money, but benevolence was not limited to acts of materialism. Where the majority were content to ease their philanthropic conscience by giving a few shillings through the means discussed above, others donated their time. The *Hospital* lamented in 1887 that more people could not be encouraged to be active in the hospital, but those who were donated their time with energy and enthusiasm. The donation of time is not easy to quantify, but like the donation of money it had its material benefits. Men like Waterlow, Sir Francis Goldsmid, chairman of University College Hospital, Samuel Whitford, secretary to the Hospital for Sick Children, and Edmund Lushington, treasurer of Guy's, were indefatigable. Similar figures can be found at all the London hospitals. At the German Hospital between 1845 and 1898 135 men served on the Management Committee. Involvement varied, though after 1855 the length of active participation increased and most sat on committees for three or more years. Some philanthropists were more noticeable than others: Arthur Allen served on the Board of Management from 1863-1910; J. Satow during his appointment from 1848-1872 constantly visited the hospital and attending meetings. Adolphus Walbaum matched Satow's commitment. From 1845 to 1890 he was the hospital's House Secretary, present at almost every meeting and a leading influence in all the administrative decisions.<sup>215</sup> Long and active service was not unique to the German Hospital and characterised the Hospital for Sick Children's management. Without these men many London hospitals would not have been founded, and certainly would not have been able to raise money or function at the level that they did. Philanthropy in this respect remained crucial.

Philanthropy was no simple phenomenon. The motivation behind benevolence was made up of a number of inspirations that could exist simultaneously in the philanthropists' act of giving, combining altruism with self-interest and duty. No two philanthropists were inspired by the same concerns or the same set of circumstances, and each gave of their

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<sup>215</sup> GH Archive, List of Management, A/67/4.

own accord. Hospitals responded with an equally diverse range of fundraising activities that were designed to stimulate charity, make benevolence enjoyable and direct it to the hospital. Governors sought to combine activities, relying on no single tactic, as often novelty was the key to success. Other charitable societies adopted similar techniques, but hospitals were one of the most effective at generating support. The result was an endless stream of fundraising activities.

This activity raises important questions about the extent of charitable support. How important was direct philanthropy in funding the hospital? Did all hospitals rely on charity for their income? How did charity's contributions change over time? What other resources could hospitals draw on? It is to these questions that the next chapter turns to in a discussion of charity and hospital finance. Philanthropy was an important source of income, but it was not the only resource available to governors and it was not crucial to all hospitals' financial fortunes.

### 3

## Paying for the Sick Poor

‘The question of financing our large hospitals’, wrote Henry Burdett in 1878, ‘has never yet received the attention which it deserves’.<sup>1</sup> By the 1890s no pronouncement could be made on the London hospitals without some reference to their funding. Burdett had not inspired a new enthusiasm for hospital finance, merely outlined a problem that attracted increased interest as the financial position of London’s hospitals deteriorated. Analysis of hospital funding by historians, however, has remained one dimensional. Historical opinion on the subject can be summarised in Brand’s assessment that ‘from the establishment of the great London hospitals in the eighteenth century charitable donations formed the economic base’ of free medical care.<sup>2</sup> Can this view be sustained, especially when philanthropy was rarely confined to a simple motive or a single means of giving?

### 1. CONTEMPORARY VIEWS, PRACTICAL REALITIES

Victorians were convinced that theirs was a ‘land of charity’.<sup>3</sup> Sydney Waterlow, in his position as chairman of the Sunday Fund, felt that the potential of charitable contributions was limitless, but hospital governors were all too aware that benevolence was a finite resource.<sup>4</sup> They continued, however, to hope that philanthropy would meet all their financial needs. When the governors of the Royal Chest Hospital launched a special building appeal in 1893, it was expected that ‘charity would put [its] shoulder to the wheel’.<sup>5</sup> The governors of University College Hospital shared a similar faith, believing

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<sup>1</sup> *BMJ*, 1 (1878), 320.

<sup>2</sup> J.Brand, *Doctors and the State* (Baltimore, 1965), 192.

<sup>3</sup> *Hospital*, 2 February 1889, 278; *Charity Record & Philanthropic Messenger*, 31 July 1867, 1.

<sup>4</sup> *Charity Record & Philanthropic News*, 2 (1882), 13.

<sup>5</sup> *Charity Record & Philanthropic News*, 13 (1893), 102.

that their £14,000 deficit would be solved by Queen Victoria's Golden Jubilee in 1887.<sup>6</sup> However, there was 'a limit to the generosity of even the most benevolently disposed persons' that even the most vigorous fundraising could not overcome.<sup>7</sup>

A survey in the *Medical Times & Gazette* in 1864 found that 46% of the London hospitals' income came from voluntary sources.<sup>8</sup> A similar investigation by the COS in 1910 reported that there had only been a 1.7% change in this figure.<sup>9</sup> Other contemporaries came to similar conclusions and illustrated that London's hospitals were not entirely supported by voluntary contributions. A study of hospitals' account books, ledgers and annual reports offers the same conclusion.<sup>10</sup> Governors, preoccupied with the problems of funding, knew that charitable income was at best precarious and therefore they erratically supplemented philanthropy with other sources of funding. The composition of finance was strongly influenced by the resources available within London's benevolent economy and by the accepted notions of hospital funding. Rarely did institutions step outside these boundaries to solve their economic problems: antagonism to the idea of state funding made the Royal Free's unsuccessful application for a government grant in 1841 an anomaly.<sup>11</sup> A firm faith in voluntarism and the idea of a minimal state ensured that even when the London hospitals appeared to face considerable economic problems from the 1880s onwards, only those on the margins of reform suggested that the state should intervene. In the Victorian hospital sector the boundaries between civil society and the state were firmly drawn and it was not until the 1920s that the possibility of limited state funding became a temporary reality.<sup>12</sup> Every other available

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<sup>6</sup> *Charity*, August 1887, 60.

<sup>7</sup> *Charity Record & Philanthropic News*, 3 (1883), 40.

<sup>8</sup> *Medical Times & Gazette*, 2 (1864), 98.

<sup>9</sup> C.S.Loach, *Charity and Social Life* (1910), 487-8.

<sup>10</sup> See Appendix on classification and the method of calculating hospital income.

<sup>11</sup> R.W.Chalmers, *Hospitals and the State* (1928), 102.

<sup>12</sup> See Chapter 8.

resource, however, was exploited, though funding remained 'to a great extent a matter of chance and speculation'.<sup>13</sup>

There were 'great differences in [hospitals'] modes of raising income' and each institution's financial make-up was partly conditioned by its location, age and nature.<sup>14</sup> However, using the evidence available from individual hospitals, it is possible to reconstruct their finances. Hospitals drew their income from five principle types of funding: from direct and indirect philanthropy, from the property and investments, from the hospitals' function as a medical institution, and from loans. Hospital finance was not a matter of dependence on any one type of funding, but a reliance on several related sources of income that together made up the individual hospital's structure of funding.

## 2. FUNDING THE HOSPITAL: CHARITABLE INCOME

Direct philanthropy remained the largest component in the hospitals' structure of income. All hospitals received some money from charity, though the amount contributed to the endowed hospitals remained relatively small in comparison with their other sources of funding. Governors as shown in Chapter 2 carried out a variety of fundraising initiatives to encourage contributions, but they were dependent on the extent of charitable resources available within the benevolent economy. Between 1850 and 1898, London's benevolent economy expanded. According to Sampson Low's survey of metropolitan charities in 1850, £1,022,846 was contributed to benevolent societies, by 1910 the amount had risen to £2,150,000, though the number of societies had also greatly increased.<sup>15</sup> Hospitals experienced a similar increase in charitable income, although as shown below philanthropy's relative financial contribution declined in the overall structure of income. The trend was not a smooth one. Contemporaries worried about annual fluctuations in contributions, but income from voluntary contributions gradually rose. The increase must partly be attributed to the performance of the London economy and Britain's rising GNP

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<sup>13</sup> *BMJ*, 2 (1892), 31.

<sup>14</sup> *Times*, 26 April 1878, 9.

<sup>15</sup> S.Low, *Charities of London* (1850); Loch, *Charity and Social Life*, 487-8.

which, according to Feinstein, stood at £642 million in 1855 and £1,459 million in 1895.<sup>16</sup> With a rising GNP and an increase in the standard of living more money was available for charitable purposes, though donations did not mount at the same rate as national income. All classes contributed at a formal and informal level, but the 'insecurity of working-class income' and the importance of middle-class and professional occupations in London ensured that charity was funded mainly by the middle classes.<sup>17</sup> On average middle-class families spent 10.7% of their income on charity in the 1890s, a form of voluntary 'taxation' which was less controversial and seemed less oppressive than the state's fundraising.<sup>18</sup> With a change in the standard of living, caused by falling prices and a reduction in family size, and an increase in middle-class incomes identified by Banks, London's charitable contributions corresponding increased, suggesting a close relationship between the two.<sup>19</sup> A comparison of the small amounts left by middle-class benefactors in late seventeenth- and early eighteenth-century and the relatively larger average size of legacies given to the Victorian hospitals, shows a clear rise in middle-class incomes.<sup>20</sup> Bequests are not an accurate barometer of wealth as they remained unpredictable, but they do reflect an increase in middle-class charitable expenditure and their stable commitment to voluntarism.

Whereas charitable income was rising within the benevolent economy, individual institutions had a different ability to attract direct philanthropy. Hake's survey illustrates how different hospital types had a distinct appeal to charity, but his assessment does not tell the whole story:

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<sup>16</sup> C.H. Feinstein, *National Income, Expenditure and Output of the United Kingdom 1855-1965*, Table 1, T4-5.

<sup>17</sup> P. Johnson, *Saving and Spending: The Working-Class Economy in Britain 1870-1939* (Oxford, 1985), 219.

<sup>18</sup> *Statistics of Middle-Class Expenditure*, British Library of Political and Economic Science, Pamphlet HD6/D267, Table IX cited in F.K. Prochaska, *Women and Philanthropy in Nineteenth Century England* (Oxford, 1980), 21.

<sup>19</sup> J.A. Banks, *Prosperity and Parenthood: A Study of family Planning Among the Victorian Middle Classes* (1954), 104-13, 132-4.

<sup>20</sup> P. Earle, *The Making of the English Middle Class* (1989), 315-19.

Table 3.1: Income from Direct Philanthropy by Institution (1892).

Hospital Type	Number	Total Income	Income from Charity	Percent
General	21	£185,137	£139,151	75.2
Chest	5	£31,445	£25,842	82.2
Children's	11	£28,002	£20,235	72.3
Lying-in	4	£9,203	£2,757	29.9
Women's	6	£13,373	£13,263	99.2
Other Specialist	20	£40,624	£25,873	63.7
Convalescent	15	£21,154	£8,251	39.0
Cottage	6	£2,180	£825	37.8
Other	5	£13,432	£5,425	40.4
<b>TOTAL</b>	<b>93</b>	<b>£344,550</b>	<b>£241,622</b>	<b>70.1</b>

Source: A.E.Hake, *Suffering London* (1892).

Contemporaries complained that specialist hospitals, through their 'increased energy and continuous and extensive appeals', attracted a greater amount of charitable income than other hospitals.<sup>21</sup> The Lord Mayor of London in 1892 felt that the Royal Chest Hospital was 'almost entirely dependent for its support on voluntary contributions'.<sup>22</sup> This was an exaggeration. However, both the Royal Chest Hospital and the Hospital for Sick Children had a higher level of philanthropic support than many general hospitals at a time when charity was assuming a less prominent role in hospital funding. At the Royal Chest Hospital, direct philanthropy increased its financial importance, rising from 67.1% of the total income between 1850 and 1855, to 86.4% between 1890 and 1895.<sup>23</sup> The reasons for this difference are explained in the following chapter, but are linked to these hospitals' specialist nature and age which encouraged contributions and initially removed the need to develop other sources of income.

<sup>21</sup> *Hospital*, 3 September 1892, 381.

<sup>22</sup> *Charity Record & Philanthropic News*, 12 (1892), 108.

<sup>23</sup> RCH Annual Reports, 1850-1895.

Subscriptions were seen as the only 'reliable' source of charitable income and the Prince of Wales believed that they were 'the true test of a charity's reputation'.<sup>24</sup> During the eighteenth century, subscriptions for most voluntary hospitals had provided between half and three quarters of their income, though at the Bath Infirmary subscriptions represented under a quarter of the total income.<sup>25</sup> One speaker at the Social Science Association's conference in July 1883, noted that subscriptions at provincial hospitals still represented their most important source of income.<sup>26</sup> At the Royal West Sussex Hospital, Chichester, subscriptions formed 63.4% of the total income between 1850 and 1855. Even by the end of the nineteenth century, subscriptions remained its most significant source of funding, representing 31.4% of the income.<sup>27</sup> The same was not true of London. Burdett estimated in 1890 that subscriptions provided only 12% of the income of London's general hospitals.<sup>28</sup> There are two reasons for this difference. The first relates to the relative amount of income subscriptions generated. The small individual monetary contribution that subscriptions represented limited their total financial contribution.<sup>29</sup> Although London's hospitals collected more from subscriptions than many provincial institutions, subscriptions' overall contribution was reduced by the amount of money that was raised from other sources. The second reason reflects the nature of London's civil society and the structure of its benevolent economy. In London hospitals were only one of a number of charitable institutions competing for funds. Competition was found outside London, but the sheer number of charitable societies in London stretched the amount that could be raised by individual societies.

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<sup>24</sup> *Lancet*, 2 (1883), 72-3.

<sup>25</sup> G.B.Risse, *Hospital Life in Enlightenment Scotland: Care and Teaching of the Royal Edinburgh Infirmary* (Cambridge, 1986); W.Brockbank, *Portrait of a Hospital 1752-1948* (1952); A.Borsay, 'Cash and Conscience: Financing the General Hospital at Bath c1738-1750', *Social History of Medicine*, 4 (1991), 211-12.

<sup>26</sup> *BMJ*, 2 (1883), 32.

<sup>27</sup> Royal West Sussex Hospital Archive, Chichester Records Office, West Sussex, RWSH/26-28.

<sup>28</sup> *Hospital*, 8 March 1890, 353.

<sup>29</sup> See pages 61-2.



Table 3.2: Income from Direct Philanthropy (percentage of total income).

Hospital	Source of Income	1850-1855	1863-1865	1870-1875	1890-1895
St.Bartholomew's Hospital <sup>1</sup>	Donations	-	1.5	0.9	0.5
	Legacies	-	0.2	2.1	2.7
Guy's <sup>2</sup>	Subscriptions	-	-	-	-
	Donations	0.4	-	0.2	23.0
	Legacies	-	-	2.1	-
University College Hospital	Subscriptions	15.6	-	8.4	7.9
	Donations	27.7	-	30.4	21.5
	Legacies	12.4	-	16.2	24.4
London Hospital	Subscriptions	5.0	-	3.5	4.7
	Donations	11.0	-	17.3	11.2
	Legacies	5.6	-	6.3	19.9
	Collections	0.3	-	0.2	0.8
	Special Fund	-	-	12.3	1.3
Royal Chest Hospital	Subscriptions	46.5	-	27.8	26.2
	Donations	20.6	-	54.6	39.9
	Legacies	-	-	0.3	18.8
	Collections	-	-	1.3	0.9
	Entertainments	-	-	-	0.5
Hospital for Sick Children	Subscriptions	28.8	-	19.9	16.6
	Donations	26.8	-	39.2	22.4
	Legacies	4.8	-	9.8	23.7
	Collections	8.6	-	0.7	0.4
	Entertainments	-	-	-	0.2
	Endowment Fund	-	-	-	4.8
German Hospital <sup>3</sup>	Subscriptions	23.5	-	13.2	18.0
	Donations	39.9	-	37.4	34.4
	Legacies	2.1	-	2.5	6.3
		8.3	-	0.2	0.5

Notes:

<sup>1</sup> For St.Bartholomew's no ledgers exist for the period 1850-1855.<sup>2</sup> For Guy's 1853 is the first available year for a breakdown of the hospital accounts.<sup>3</sup> For the German Hospital 1851 is the first available year for a breakdown of the hospital accounts.

Source: Annual Reports 1850-1895; Guy's Archive, Financial Abstracts, D19/1-3, A94/1; SBH Archive, General Account Books, Hb/23/3-4.

Subscriptions were vital for hospitals in the first decade after their foundation, but as the hospital aged other sources of philanthropy came to dominate, so reducing subscriptions' relative financial contribution. For established hospitals (ie those more than 10 years old) donations provided direct philanthropy's most significant financial contribution and fundraising was primarily directed at stimulating and collecting donations. The NSPCC, even with its 46,000 subscribers in 1899, and many other large charities were equally dependent on this source of income.<sup>30</sup> At Guy's the governors, under pressure from the Charity Commission, used £15,000 in donations from its 1886 appeal to cover its overdraft.<sup>31</sup> Legacies were more erratic, but provided a permanent feature of hospital funding. At St.Bartholomew's they provided the hospital's main source of charitable funding shifting in the eighteenth century from gifts of land to cash gifts under the influence of the Mortmain Act. After 1870 the number and amount of these legacies increased and assumed a small, but significant part of the hospital's income. Bequests, it was noted in 1895, kept hospitals 'afloat' and this created anxiety for their future.<sup>32</sup> Many governors initially hoped to use legacies as a form of investment to increase their hospital's reliable income, but as expenditure rose bequests were

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<sup>30</sup> G.K.Behlmer, *Child Abuse and Moral Reform in England 1870-1908* (Stanford, 1982), 143.

<sup>31</sup> Guy's Archive, Letters of the Charity Commission, A172/2. Historians have seen the Charity Commission as a weak body which gradually lost its initial momentum in the face of its inability to rationalise charitable endowments, citing contemporary dissatisfaction with the extent of the Commission's powers [See D.Owen, *English Philanthropy 1660-1960* (Cambridge, Mass., 1964), 299-329 and R.Tompson, *The Charity Commission and the Age of Reform* (1979) for the Commission's foundation]. Perhaps this view is too pessimistic. The Commission could only influence the endowed hospitals, but governors of other hospitals wrote to it for information and advice on legacies. At the endowed hospitals the Charity Commission had more influence on a practical level than has been assumed. It used its power to sanction developments, particularly loans, as a handle on policy. At Guy's and St.Thomas's the Charity Commission used its influence to encourage the governors to adopt new financial policies in the 1880s, particularly the introduction of patient payment schemes (see below). There was no intervention to alter the pattern of endowments, perhaps because they continued to produce a sizeable income even after 1880. However, the Commission used its influence to manoeuvre both hospitals into action. It could be said that the Commission persuaded both hospitals to address their position in a positive manner and Guy's and St.Thomas's responded accordingly.

<sup>32</sup> H.C.Burdett, *Hospitals and Charities Annual* (1895), 99.

increasingly diverted to the general fund. University College Hospital relied too heavily on legacies to meet its financial problems and bequests were used to pay debts, leaving little room for manoeuvre. Few other hospitals depended on the 'dead hand' of legacies to this extent, but even the most carefully managed felt that without bequests their finances would be in a 'deplorable condition'.<sup>33</sup> The London, like the Hospital for Sick Children and the Middlesex, used legacies to meet their current running expenses, thereby preventing a deficit. Legacies, if not reliable were seen as an important and often fortuitous source of funding.

Income from direct philanthropy and the hospitals' fundraising tactics attracted the most public attention, publicity and criticism. Charitable contributions characterised hospitals as benevolent and voluntary institutions, but even in the eighteenth century income from philanthropy was unable to meet the hospitals' running costs. Other sources of funding were used to fund the gap between income and expenditure that charity could not fill.

### 3. INDIRECT PHILANTHROPY

The foundation of the Sunday Fund in 1873 created a new channel for voluntary contributions.<sup>34</sup> In the following year, the creation of the Saturday Fund extended the amount that was collected from indirect philanthropy. Between them the funds provided a new and valued source of funding. Governors made positive attempts to ensure that they received the maximum grant they were entitled to, viewing any fall in their grant with concern. The funds could not solve the London hospitals' financial problems, but they went some way to ensure that their precarious economic position was moderated.

The Sunday Fund was not at first an unwarranted success and disappointed many of its initial supporters. However, after 1878 the Fund gathered momentum, raising as much as £43,679 in the 1894 and distributing 96% of the collection to 127 hospitals and

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<sup>33</sup> *Daily Mail*, 16 October 1897, 4.

<sup>34</sup> For the development of the Sunday Fund see pages 78-84.



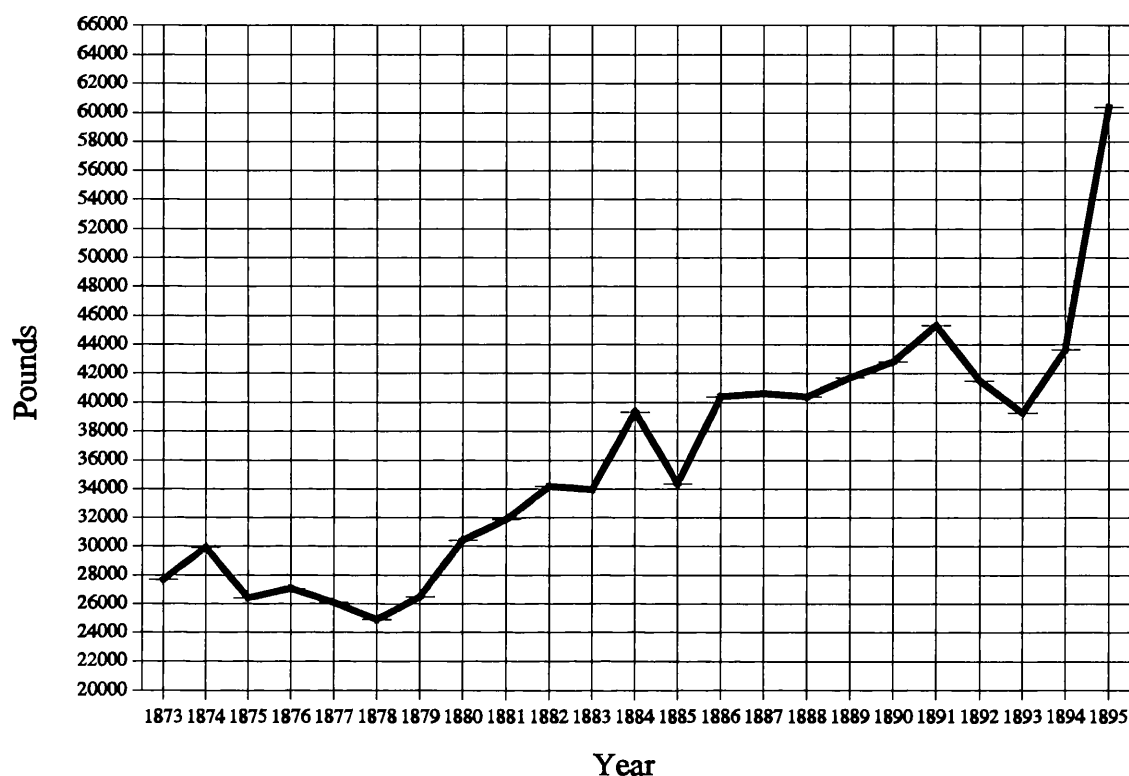
### "MORE CRY THAN WOOL."

MR. PUNCH: "WELL, WELL, DEAR NADAX! NO DOUBT YOU'LL DO MORE TEXT TIME. AND-ER- VISITORS ARE EXPENSIVE; ONLY, THERE ARE CERTAIN FOLK-AS THE IMMORTAL BARD OBSERVES- WHO 'WILL NOT GIVE A DOT TO BELIEVE A LAME BEGGAR, WHEN THEY WILL LAY OUT TEN TO SEE A RHYME FERGIAN!'"

Source: *Punch*, 28 June 1873, 257.

55 dispensaries.<sup>35</sup> From 1873 to 1894 a total of £725,647 was raised, but not all were entirely satisfied as the need for an additional £100,000 per annum became apparent:

Figure 3.1: Sunday Fund's Total Collections (1873-1895)



Source: *Lancet*, 1873-1895.

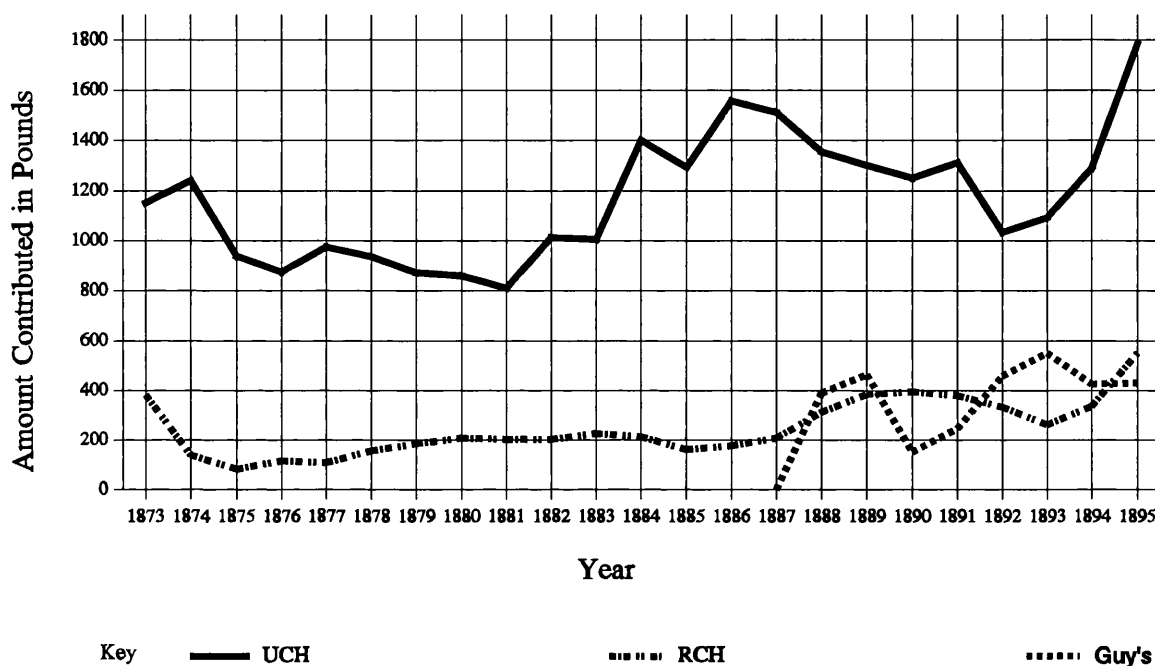
In 1881 Burdett expressed a growing opinion that the collections were 'lamentably small' and in 1894 the *Charity Record & Philanthropic News* inaccurately predicted that it was on the 'wane'.<sup>36</sup> This should not belittle the Fund's development. The Sunday Fund was successful at attracting a large body of support and its collections reflected the wider ebb and flow of metropolitan charity, mirroring fluctuations in the trade cycle. Support was mobilised through incessant publicity and the Fund's low administrative costs created a favourable image of efficient and economical management that contrasted with the

<sup>35</sup> *Lancet*, 2 (1894), 1509.

<sup>36</sup> *Charity Record & Philanthropic News*, 14 (1894), 235.

running of other charities. Fluctuations had a direct bearing on the amounts awarded to individual hospitals:

Figure 3.2: Sunday Fund Grants to University College Hospital, Royal Chest Hospital and Guy's (1873-1895)



Source: Annual Reports 1873-1895.

A dramatic increase in the Fund's income in 1883 coincided with the publicity surrounding the *Bitter Cry of Outcast London*, which heightened concerns over poverty and encouraged philanthropy.<sup>37</sup> The gradual increase during the 1880s, only interrupted when benevolence was diverted to a special Mansion House Fund in 1885-6 after worker demonstrations in the West End aroused public concern, was a product of this emerging awareness of poverty combined with the growth of national income. The Fund received a further boost in 1895 when profits from the 'South African Boom' in the City were

<sup>37</sup> E.P.Henock, 'Poverty and Social Theory in England: the Experience of the Eighteen-Eighties', *Social History*, 1 (1976), 67.

partially redirected into it through the efforts of Burdett. The liberality of Messrs Burdett & Harris, Messrs Pym & Vaungham of the Stock Exchange, 'and other City friends' pushed receipts to a total of £60,000. The city plutocracy had aligned itself behind the capital's hospitals, a tendency that was strengthened with the foundation of the Prince of Wales Hospital Fund in 1897. To maintain support poor collection returns were explained by short-term economic problems, epidemics (particularly influenza in 1892 and 1893), the influence of the weather, and even the death of Archbishop Magee, a prominent supporter of the NSPCC, in 1891. The establishment of the Prince of Wales Hospital Fund had a longer term bearing. At a meeting in 1898, the chairman of the Sunday Fund explained that 'many of their large contributors, who used to give £500 or £1000 had either transferred to the Prince of Wales Fund or had divided it'.<sup>38</sup> The Fund's organisers hoped to find another explanation for its declining success; some even blamed Waterlow's prejudice against the specialist hospitals, but in fact both funds competed for similar charitable resources.<sup>39</sup> From the outset, the Prince of Wales Fund was more effective in mobilising philanthropic support.

The Sunday Fund drew most of its collections from the single Sunday collection in June which became the focus of the movement. None could rival Canon Flemming, Vicar of St. Michael's, Chester Square, who in 1894 collected a record amount of £1,202 15s.<sup>40</sup> Flemming was an Anglican minister, reflecting the Church of England's social prominence, wealth and importance in collections. Anglican congregations contained the highest proportion of middle- and upper-class citizens in London, ensuring that collections in Anglican churches drew on the social groups that could most afford the fashion of philanthropy. It was also the largest religious body. In 1886-7, 13.5% of Londoners attended a Church of England service and despite a fall in attendance to 9.4% by 1902-3, no other denomination could rival its influential position.<sup>41</sup>

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<sup>38</sup> *Times*, 4 August 1898, 7.

<sup>39</sup> *Hospital*, 13 August 1898, 343.

<sup>40</sup> *Lancet*, 2 (1894), 1509.

<sup>41</sup> H. Mcleod, *Class and Religion in the Late Victorian City* (1974), 314.

Table 3.3: Congregational Contributions.

Denomination:	1884	%	1894	%
Church of England	£25,127	81.0	£28,368	84.3
Congregationalist	£2,102	6.8	£1,499	4.5
Baptists	£1,102	3.5	£836	2.5
Wesleyans	£1,057	3.4	£979	2.9
Presbyterians	£708	2.3	£1,064	3.2
Roman Catholics	£523	1.7	£484	1.4
Unitarians	£245	0.8	£278	0.8
Quakers	£162	0.5	£126	0.4
TOTAL	£31, 036	100.0	£33, 634	100.0

Source: H.C.Burdett, *Hospitals and Charities Annual* (1895), 211.

This does not completely explain why other denominations contributed smaller amounts. All denominations faced problems of attendance, but the Church of England retained its position, not because of its disproportionate stress on the merits of benevolence to the sick poor, or the wealth and size of its congregations, but because it had few other outlets for charitable action. Other denominations had their own charitable tendencies and patronised voluntary societies that matched their religious nature. Nonconformists had their Dorcas meetings, at which ladies of the chapel met to drink tea and make clothes for the poor; Catholicism tried to dominate the whole non-working life of its believers. The Catholic Church provided clubs for each distinctive group and a host of welfare services, including loans at a low rate of interest. Aid to the Irish, educational interests, and the work of the Society of St.Vincent de Paul which had few active members but an income of £1,461 5s 7d in 1895, dominated its philanthropic activities.<sup>42</sup> Within this established network of church charity the Sunday Fund was an intruder and consequently assumed a peripheral importance.

The Fund's activities were not limited to church collections: it also accepted donations and legacies from a wide range of sources, but most support came from

<sup>42</sup> St.Vincent de Paul Society 1895 Annual Report.



collections. Contributions were generally small, averaging 2d. per head in 1898.<sup>43</sup> Not all gave, though evasion was difficult, at least for those attending church. It is impossible to determine how many went as far as Jack Brown, a fictional character in the *Lancet* who remained 'blind drunk' for the entire day to avoid making a contribution.<sup>44</sup> However, the Fund never reached its expected target income.

The Metropolitan Hospital Saturday Fund, founded in 1873, was the working-class equivalent to the Sunday Fund. The movement built on provincial initiatives started in Liverpool and aimed to 'aid in every possible way to perfect the system of Medical relief in the Metropolis by supporting the Hospitals and kindred institutions'.<sup>45</sup> Both funds shared a common concern to raise the London hospitals' income, but from the start the Saturday Fund aroused hostility. Burdett attacked it as injurious and extravagant and as a movement that did not have the sympathy of the working classes. Others criticised the Fund as a misguided provident scheme with exorbitant expenses that were a waste of charitable resources. Socialists saw it as a capitalist dupe. These criticisms did not come from a sense of class hostility, but often from a feeling that the Fund was an unwelcomed competitor that demanded too much for its support. Its inauspicious beginnings only fuelled criticisms and throughout its existence it constantly worked to reduce its expenditure. The first collection was a disappointment and the movement blamed its lack of support on the press's unenthusiastic reception.<sup>46</sup> The next three collections were no better, but from 1878 the amount collected began to rise and confidence in the Fund increased:

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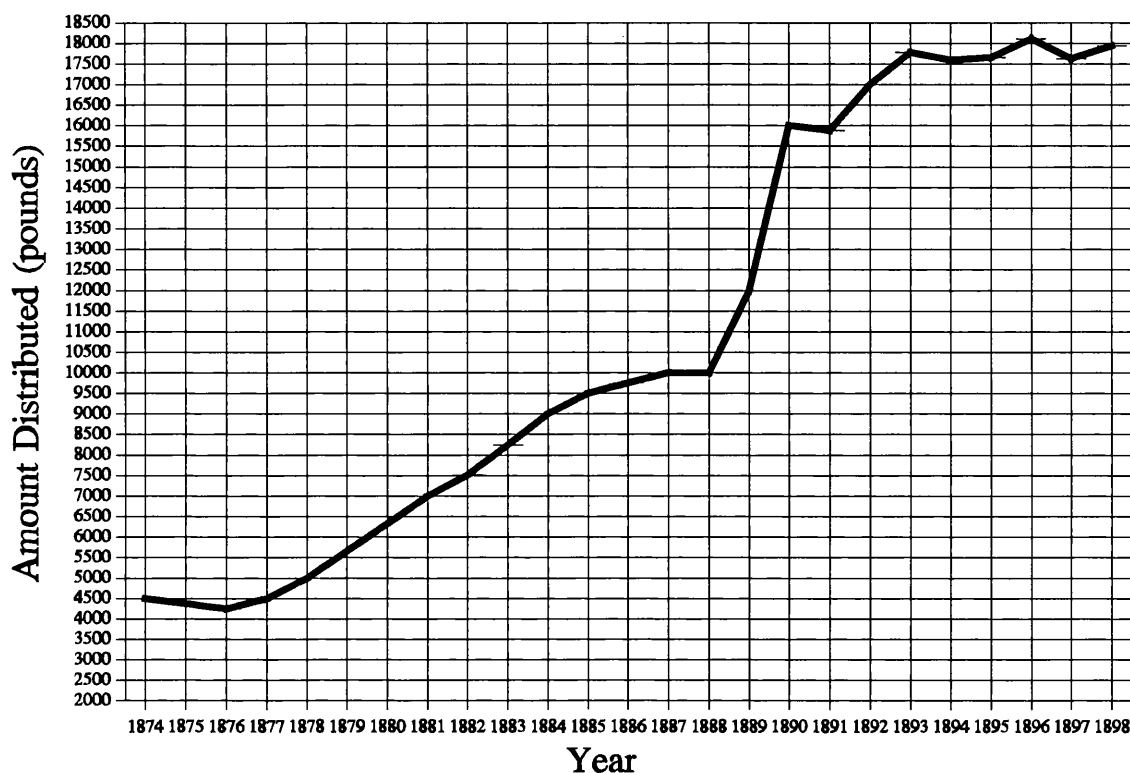
<sup>43</sup> *Lancet*, 2 (1895), 1052-3.

<sup>44</sup> *Lancet*, 1 (1886), 1195.

<sup>45</sup> H.C.Burdett, *Hospital Sunday and Hospital Saturday* (1884), 8-9; *Hospital Saturday Fund Journal*, December 1897, 8; S.Yeo, *Religion and Voluntary Organisation in Crisis* (1976), 216-218, describes the evolution of a similar movement in Reading, while H.Marland, *Medicine and Society in Wakefield and Huddersfield 1780-1870* (Cambridge, 1987), 158-9 shows the development of a Saturday Fund in the Huddersfield area.

<sup>46</sup> *Medical Times & Gazette*, 2 (1874), 662.

Figure 3.3: Saturday Fund - Amount Distributed.



Source: *BMJ*, 1874-1898.

The organisers remained dissatisfied that more had not been achieved, but they were aware that the Sunday Fund appealed to the middle classes and rich Anglican and Nonconformist congregations while they were reliant on working-class support. The *Morning Post* blamed the Saturday Fund's poor results on the working classes' refusal to accept its responsibilities, but the movement dismissed this idea and sought other explanations.<sup>47</sup> The weather was blamed and the Fund complained of competition with the many local collection schemes that it honoured but which did not appear to respect its activities.<sup>48</sup> As experience was accumulated, the Fund managed to cut its expenses from 35.2% of the amount collected in 1874, to 14.5% in 1885, enabling it to project a

<sup>47</sup> Cited in the *Lancet*, 2 (1874), 705.

<sup>48</sup> *Hospital Saturday Fund Journal*, December 1897, 8.

more realistic impression of its usefulness.<sup>49</sup> A change in the Fund's fortunes saw a rise in collections. The Golden Jubilee produced a patriotic upsurge in the organisation's activities as 'monster demonstrations' and collections were organised in Victoria Park, but this had little influence as competition for charitable resources remained intense.<sup>50</sup> The sudden rise in collections from 1889 was helped by the introduction of a 'penny-a-week' collection scheme that aimed to raise £100,000. The new scheme generated widespread interest and though it did not raise the amount expected, it served to boost the Fund's collections and maintain them at a higher level.<sup>51</sup> By 1894 the Saturday Fund was dividing £17,500 between 165 participating institutions, but many remained dissatisfied.

From the start, the Saturday Fund was heralded as a working-class collection scheme, an 'appeal to the "pence of the workman"'.<sup>52</sup> Collections were centred on the capital's workshops and by 1884 the Fund was sending out 20,000 collection sheets to businesses in London.<sup>53</sup> The Workshop and Streets Collection Committee worked hard to increase the Fund's support. Its members visited every business that wanted to hold a collection and insisted that £5 had to be contributed annually for it to remain in the scheme.<sup>54</sup> In exchange, the Fund attempted to acquire from the hospitals it supported the right to admit patients and then distribute these rights to participants in the Fund. Hospital governors did not universally welcome the move. They resisted the distribution of admissions' rights, hoping to balance the financial support received from the Fund with their own subscribers' interests in an environment where the medical profession increasingly dictated which patients were admitted. Critics saw the Fund as a misguided attempt at working-class self-help and felt that small contributions created the erroneous impression that participants had a right to treatment. Opposition limited the Fund's

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<sup>49</sup> *BMJ*, 1 (1886), 455.

<sup>50</sup> *Hospital*, 11 June 1887, 177.

<sup>51</sup> *BMJ*, 1 (1889), 50.

<sup>52</sup> *Charity*, June 1887, 15.

<sup>53</sup> *Charity Record & Philanthropic News*, 4 (1884), 278.

<sup>54</sup> *Hospital Saturday Fund Journal*, December 1897, 6.

activities, but by 1897 it was estimated that the Fund was giving back the equivalent of 30% of its collections in services to its supporters.<sup>55</sup>

The Saturday Fund was never entirely a working-class organisation; from the start its character was transcended through a number of fundraising activities that aimed to collect money from all classes. Collection boxes were placed in railway stations and post offices, while street collections, run and staffed by 'ladies', were organised on one Saturday in every year. From the 1890s onwards, sport and cycling clubs organised special events to raise money, capitalising on the movement towards recreational sport and working-class leisure.<sup>56</sup> Individuals gave their effort voluntarily and London was divided into thirty districts, each with an organisational committee composed of local working men, employers and middle-class activists.<sup>57</sup> A carefully regulated and audited management could not prevent fraud, which remained a major problem for the Fund. The theft of 13 collection boxes in the Norwood district in 1893 generated widespread public concern and minor cases of fraud were common.<sup>58</sup> The Fund, however, persisted. Camberwell, St.George's and Westminster, Southwark, and Woolwich consistently contributed the largest collections, but despite the obvious success of the scheme, street collections increasingly attracted staunch opposition. The *BMJ* felt that street collections were 'organised begging' and in 1895 the COS arranged a conference to discuss how they might be stopped.<sup>59</sup> The Fund's organisers were aware of the hostility collections created. After lengthy discussion in 1897 they finally abandoned street collections after the metropolitan police had lodged a strong protest about the disruption they created. The Fund's move was partly an attempt to counter criticism, but also reflected a fall in the

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<sup>55</sup> *Charity Record & Philanthropic News*, 17 (1897), 470.

<sup>56</sup> *Hospital*, 14 January 1893, 250; see H.E.Meller, *Leisure and the Changing City 1879-1914* (1976) or R.Holt, *Sport and the British* (Oxford, 1989).

<sup>57</sup> *Charity*, July 1887, 40.

<sup>58</sup> Family Welfare Association records, Greater London Records Office (hereafter FWA) FWA, C/D61/1. Most cases of fraud were similar to the £4 stolen in 1893 by a man disguised as an official collector and the Fund was always keen to show that it was a responsible organisation by pressing for prosecution: *Hospital Saturday Fund Journal*, December 1893, 2.

<sup>59</sup> *BMJ*, 2 (1874), 468; *Charity Record & Philanthropic News*, 15 (1895), 60.

amount street collections raised. From a high point in 1892 when £5,925 was collected, street collections had fallen to £4,642 17s 4d in 1896.<sup>60</sup> A new strategy of fundraising was adopted: private collections were organised, meetings were held, and the Fund started to advertise for donations.<sup>61</sup> Many consequently feared that the 1898 collection would be a disaster: despite a 7.8% rise in the amount collected in workshops and a fall in expenses, the 1898 collection raised £2,000 less than in 1897.<sup>62</sup> The collection, however, was deemed 'satisfactory' and even the Fund's critics felt that it had acted with sensitivity and courage to abandon its traditional practices.<sup>63</sup>

Table 3.4: Institutions Assisted by the Sunday and Saturday Funds, 1897.

Institution	Sunday Fund			Saturday Fund		
	No.	%	Amount	No.	%	Amount
General Hospitals	26	51.2	£22,086 15s 1d	28	36.5	£6,566 5s
Special Hospitals	57	31.7	£13,650 6s 8d	64	34.9	£6,289 1s
Cottage Hospitals	12	1.2	£511 17s 4d	5	0.8	£140
Convalescent Homes	23	6.8	£2,950 14s 2d	25	12.3	£2,209 18s
Dispensaries	55	2.8	£1,190 19s	37	5.4	£982 19s
Miscellaneous	7	1.2	£517 5s 10d	22	4.5	£812 8s 8d
Surgical Appliances	3,632	5.0	£2,140 16s 11d	2,782	5.6	£1,009 7s
TOTAL	-		£43, 046 3s 0d	-		£18, 009 18s 8d

Source: *Hospital Saturday Fund Journal*, December 1897, 2.

<sup>60</sup> *Hospital Saturday Fund Journal*, September 1894, 53.

<sup>61</sup> *Hospital Saturday Fund Journal*, March 1898, 2.

<sup>62</sup> *Charity Record & Philanthropic News*, 18 (1898), 389; 416.

<sup>63</sup> *Hospital Saturday Fund Journal*, December 1898, 1.

The distribution of grants by both the Sunday Fund and the Saturday Fund was carefully controlled by a distribution committee and elaborate rules and procedures were established to work out each hospital's grant. The Sunday Fund distributed grants according to the hospital's expenditure and the Saturday Fund assessed hospitals on the amount of relief they provided.<sup>64</sup> The main emphasis of the Saturday Fund remained on the general and specialist hospitals, but with a broad definition of 'kindred institutions' it provided surgical appliances and assisted dispensaries, ambulance services and convalescent homes. Most of the Sunday Fund's grants, however, went to the non-endowed general hospitals; specialist hospitals were only reluctantly supported. General hospitals were the prime beneficiaries of both funds because they treated the largest number of patients and had the most significant impact on suffering.

Individual hospital collection schemes were of a more localised benefit. The London's People's Five Shillings Subscriptions Fund and University College Hospital's People's Contribution Fund subscribed to a similar rhetoric of indirect philanthropy, but they remained more organised collection schemes than benevolent funds.<sup>65</sup> The difference rested on the nature of the two types of collection. The organised collection schemes did not affect the metropolitan hospitals' level of income and were designed, unlike the benevolent funds, to solely raise the London's and University College Hospital's level of philanthropic funding. Income was not distributed on merit, merely assigned to each hospitals' general fund. Between 1871 and 1898 the People's Five Shillings Subscriptions Fund collected over £45, 085 and annually provided more income for the London than the Saturday Fund.<sup>66</sup> At University College Hospital the People's Contribution Fund equally contributed more than the Saturday Fund (see figure 3.4). As organised metropolitan collection schemes for individual hospitals they proved highly effective.

Yearly figures disguise the relative importance of the Sunday Fund and Saturday Fund's grants to individual hospitals:

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<sup>64</sup> *Hospital Saturday Fund Journal*, December 1895, 31.

<sup>65</sup> For the development and aims of the two organised collection schemes see pages 77-8.

<sup>66</sup> London Hospital Annual Reports, 1871-1898.

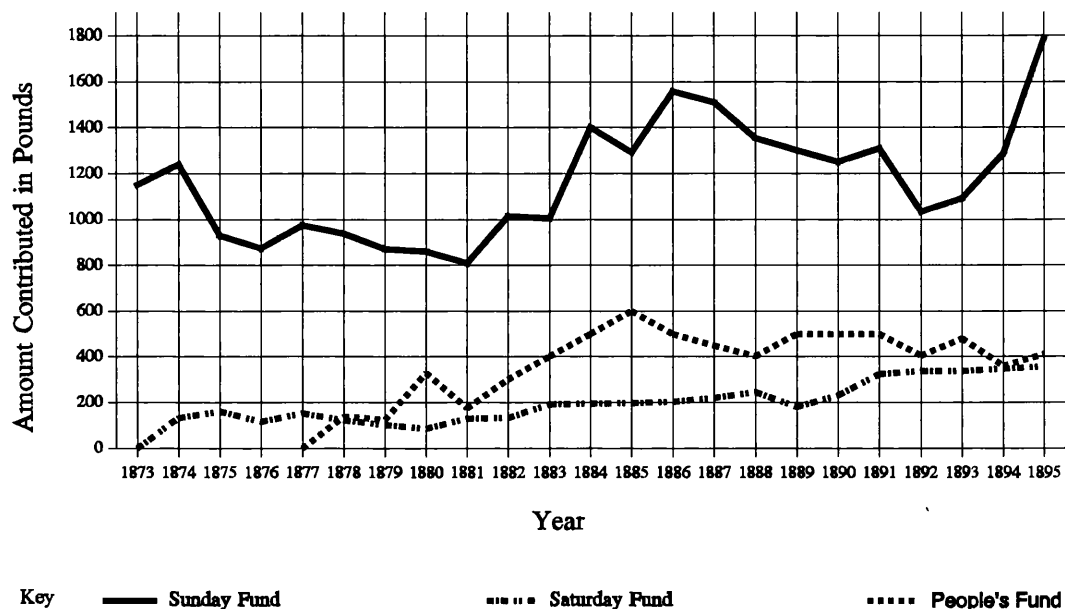
Table 3.5: Contributions of Benevolent Funds to Individual Hospitals (percentage of total income).

Hospital		1875	1895
Royal Chest Hospital	Sunday Fund	2.5	5.9
	Saturday Fund	1.6	3.6
Hospital for Sick Children	Sunday Fund	2.1	5.5
	Saturday Fund	0.3	1.2
German Hospital	Sunday Fund	5.6	5.8
	Saturday Fund	1.1	1.4
Guy's Hospital	Sunday Fund	-	2.2
	Saturday Fund	-	-
London Hospital	Sunday Fund	5.3	8.4
	Saturday Fund	-	1.5
	People's Fund	1.4	2.7

Source: Annual Reports, 1870-1895; Guy's Archive, Financial Abstracts, D19/1-3, A94/1.

The Sunday Fund, because it collected more than the Saturday Fund and had lower running costs, dominated the movement and had a more substantial impact on hospital finance. At University College Hospital the importance of the Sunday Fund is undeniable. On average it contributed twice as much to the hospital than the Saturday Fund: in 1875 benevolent funds combined contributed 6.7% of the hospital's income, the Sunday Fund on its own providing 5.9%; in 1895 the figures were 12.4 and 8.6% respectively. The fluctuations in the relative amounts contributed to the hospital matched University College Hospital's financial fortunes and the general level of support for each movement:

Figure 3.4: University College Hospital: Contributions from Funds.



Source: Annual Reports, 1873-1895.

Outside London the impact of working-class collection schemes was greater and in the period 1910-14 Cherry argues that they provided 22% of provincial hospitals' income.<sup>67</sup> Not all governors liked the benevolent funds or their methods, but many feared that a withdrawal of their support 'would mean the closing of their hospitals'.<sup>68</sup> They regarded the funds' grants as reliable and saw them as an important source of income. However, in 1887 the *BMJ* delivered a telling verdict on their activities: 'the Hospital Sunday and Hospital Saturday Funds are well-meant efforts to meet the [hospitals' financial] difficulty; but their most sanguine friends cannot pretend that they have

<sup>67</sup> S. Cherry, 'Accountability and Control in the Financing of pre-NHS Hospitals' (Modern Hospital In History Conference, University of East Anglia, unpublished paper).

<sup>68</sup> *Charity Record & Philanthropic News*, 14 (1894), 74.



solved it'.<sup>69</sup> Even indirect philanthropy had its limits, partly because it could not be separated from the constraints operating on London's benevolent economy.

#### 4. FUNDING THE HOSPITAL: NON-CHARITABLE INCOME

The editor of *Hospital Saturday Fund Journal* was aware that 'what the Hospitals want is a regular income' that was free of the 'perpetual straining' entailed by raising money from philanthropy.<sup>70</sup> Fear of a 'general falling off in the contributions of the benevolent' heightened concern about hospital funding so that by the 1890s charity was seen to be '*in extremis*'.<sup>71</sup> New schemes of raising money from charity were suggested, but governors had always sought money from non-charitable sources of funding to cover the deficit that philanthropy left. As the governors of University College Hospital explained in 1861, governors were 'bound to use every means to continue... the good work which [their] Hospital has done hitherto'.<sup>72</sup> In response, non-charitable income supplemented the money available from within the benevolent economy and at the endowed hospitals they provided the main source of funding.

Income from non-charitable sources was generated in several ways, but money from land and investments provided a constant source of funding for all London's hospitals. It must be remembered that these sources of income originally had a charitable origin, especially when most of a hospital's property would have come from a past bequest. However, over time the original nature of the gift had been submerged. Charitable contributions were converted via the purchase of land, houses and investments into a 'reliable' source of funding with an income separate from the benevolent economy. In hospital account books such sources of income were always recorded separately from the revenue generated by philanthropy. According to Pinker,

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<sup>69</sup> *BMJ*, 2 (1887), 474.

<sup>70</sup> *Hospital Saturday Fund Journal*, December 1895, 28.

<sup>71</sup> *BMJ*, 2 (1885), 1174.

<sup>72</sup> UCH 1861 Annual Report.

in 1891 'investments' represented 43.7% of hospital income in London.<sup>73</sup> At the endowed hospitals this proportion was higher and the *Lancet* rightly pronounced them an 'anomaly' in a society that generally opposed to posthumous benevolence.<sup>74</sup> In financial terms St.Bartholomew's, Guy's and St.Thomas's existed outside the benevolent economy.

St.Bartholomew's was the archetypal endowed hospital. St.Bartholomew's was not entirely dependent on its endowments, but income from property remained crucial in a hospital that found no need to attract philanthropy. Land had been slowly acquired throughout the middle ages and a series of bequests, such as Captain Bond's legacy of a house in Leadenhall Street in 1671, added to the hospital's acquisitions.<sup>75</sup> By the nineteenth century, after seven centuries of accumulation, St.Bartholomew's had become a major urban landowner, a position that guaranteed a large rental income. By the 1890s the hospital's treasurer estimated the hospital's total holdings outside London at 13,000 acres, consisting principally of country estates and farms in Essex and the south.<sup>76</sup> From the thirteenth century onwards, however, the emphasis was upon metropolitan real estate, freeing St.Bartholomew's from the financial problems other endowed institutions experienced during the agricultural depression.<sup>77</sup> Metropolitan property was favoured purely on economic grounds. London's 'appetite for increase', combined with an incessant demand for urban property that reflected 'an English fondness for the acquisition of the soil of our country', ensured that St.Bartholomew's possessed an asset that only accumulated in value.<sup>78</sup>

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<sup>73</sup> R.Pinker, *English Hospital Statistics 1861-1938* (1966), 152.

<sup>74</sup> *Lancet*, 2 (1879), 738.

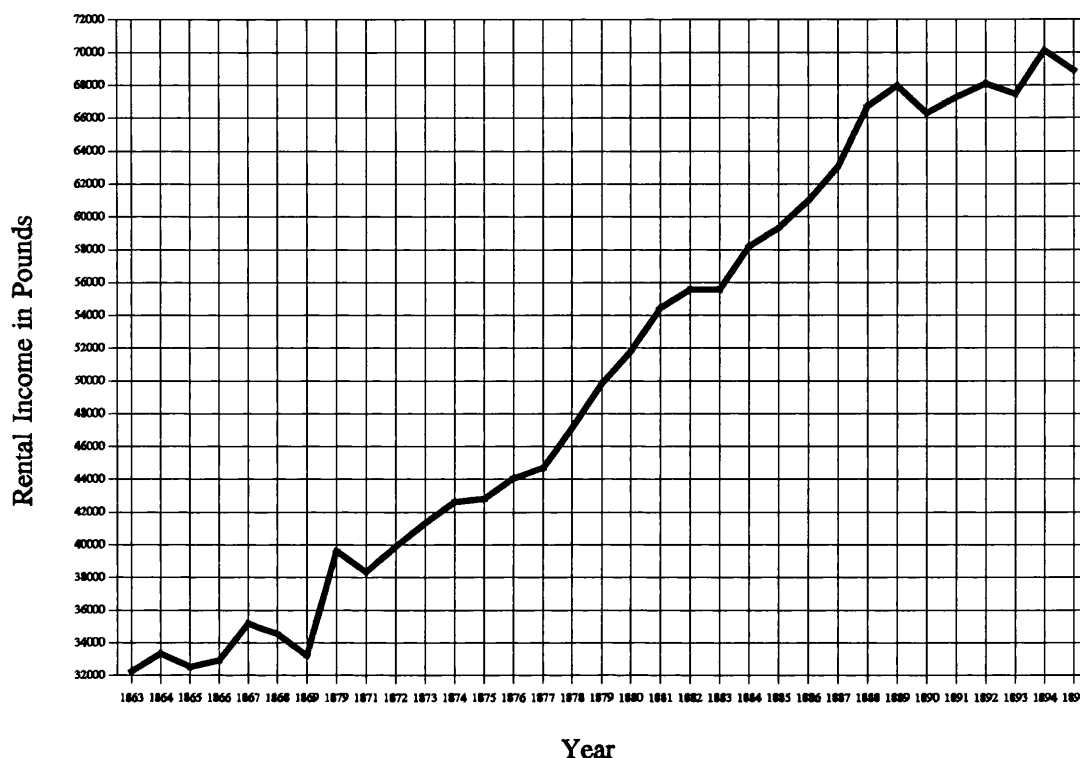
<sup>75</sup> 32nd Report of the Charity Commission, *PP* 1840 XXXII, 13-15.

<sup>76</sup> SC of the House of Lords on Metropolitan Hospitals, 1st Report, *PP* 1890 XIX, 169.

<sup>77</sup> V.Medvei, & J.Thornton, *The Royal Hospital of St.Bartholomew's 1123-1973* (1974), 32.

<sup>78</sup> Cited in D.J.Olsen, *The Growth of Victorian London* (1976), 28; P.Metcalf, *Victorian London* (1972), 2.

Figure 3.5: St.Bartholomew's: Rental Income (1863-1898)



Source: SBH Archive, General Account Books, Hb/23/3-4.

Throughout the nineteenth century, the governors invested in urban property because the return was constantly higher than that provided by rural estates: Mayland Hill Farm was leased to George Partridge for £80 per annum in 1891, while three houses in Warling Street could be let to W.H.Smith for £1,000.<sup>79</sup> From the mid-nineteenth century onwards the general notions contemporaries had of St.Bartholomew's 'connect it with resources of finance which are almost inexhaustible', though critics wrongly assumed that this encouraged extravagant expenditure.<sup>80</sup> Under these conditions the

<sup>79</sup> SBH Archive, View & Survey Books, Hc/15/3.

<sup>80</sup> *Lancet*, 1 (1861), 518.

hospital prospered, though arrears, amounting to £30,000 in the 1870s, impeded the smooth flow of income.<sup>81</sup>

Until 1879, Guy's could feel equally secure. At Guy's, however, income from endowments dominated the hospital's finances to a degree not experienced at St.Bartholomew's. Thomas Guy, having launched the scheme to found the hospital in 1721, left Guy's a total of £220,124 2s 7d when he died in 1724.<sup>82</sup> His will stipulated that this had to be invested in land to endow the hospital; any income raised from the sale of this property had to be reinvested in land, tying the hands of future governors and ensuring that most of the hospital's income would always be landed. The governors were anxious to find bargains and after the main agricultural estates had been purchased between 1724 and 1754, neighbouring property was bought as it became available, saddling the hospital with some dubious holdings.<sup>83</sup> A third of the property was held in Essex with other substantial estates in Herefordshire and Lincolnshire. Urban property was limited to the immediate area surrounding the hospital in Southwark to allow for the institution's growth. 'Till the year 1875', the hospital's treasurer explained in 1887, this had created few problems because 'the income from the joint bequests, mainly derived from their landed estates' was sufficient to fund a hospital of 650 beds.<sup>84</sup>

According to Spring, an unbusinesslike approach to land management was unusual for most landowners.<sup>85</sup> Most noble and large landowners across the country pursued an enlightened policy of estate control, improving or developing property.<sup>86</sup>

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<sup>81</sup> SBH Archive, Governors' Minutes, Ha/1/22.

<sup>82</sup> Guy's Archive, Act of Incorporation, A48/4/1.

<sup>83</sup> See D.Truman, 'The Purchase and Management of Guy's Hospital Estates 1726-1806' in C.Chalkin & J.R.Wordie (eds.), *Town and Countryside: The English Landowners in the National Economy* (1989).

<sup>84</sup> Guy's Archive, Treasurer's Report, A93/1.

<sup>85</sup> D.Spring, *The English Landed Estate in the Nineteenth Century: Its Administration* (Baltimore, 1963), 19.

<sup>86</sup> See S.Wade Martins, *A Great Estate at Work: The Holkham Estate and its Inhabitants in the Nineteenth Century* (Cambridge, 1980), 57; D.N.Cannadine, *Lords and Landlords: the Aristocracy and the Towns 1774-1967* (Leicester, 1980), 81-225; 229-381; see

Like all major landowners, St.Bartholomew's and Guy's employed a professional land agent to manage their affairs at a local level, but the governors retained absolute control over the hospital's finances. The land agent dealt with the estates' day-to-day management and reported to an estates committee appointed from among the governors. The hospitals' president and treasurer had an *ex officio* position, but it was generally the treasurer, as the most active governor, who remained the main force behind all the decisions. Contemporaries had a low opinion of how the old endowed charities in London were managed, leading to the foundation of the City Parochial Foundation in 1883 to promote reform.<sup>87</sup> The endowed hospitals were not included in the Foundation's remit, but they were the subject of similar concerns. In 1881 the *Charity Record & Philanthropic News* complained that the endowed hospitals mismanaged their estates and funds.<sup>88</sup> St.Bartholomew's, however, adopted policies that matched the efforts of other improving landowners and through careful management and judicious expansion increased the hospital's aggregate income from its estates. The governors made strenuous efforts to raise the value of the hospital's property and from 1893 all the hospital's London holdings were gradually improved.<sup>89</sup> Guy's, however, managed its estates differently, partly because Thomas Guy's will limited their field of action. Surpluses were only infrequently invested, property was not developed or urbanised and high-farming techniques were ignored until the 1880s. Part of the reason must be found in the nature of the estates which remained essentially suited to farming and presented few opportunities for improvement. The hospital's endowed nature produced a quasi-autocratic framework of management where the governors had no financial commitment to the institution, and as explained in Chapter 5 this discouraged an active policy. Meetings were poorly attended, leaving the treasurer to make all the major decisions. Until the appointment of Lushington in

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F.M.L.Thompson, 'The English Great Estate in the Nineteenth Century', *Contributions and Communications to the First International Conference of Economic History* (Paris, 1960) for a discussion of aristocratic investment.

<sup>87</sup> See V.Belcher, *The City Parochial Foundation 1891-1991* (Aldershot, 1991).

<sup>88</sup> *Charity Record & Philanthropic News*, 1 (1881), 152.

<sup>89</sup> SBH Archive, Governors' Minutes, Ha/1/26.

1876, weak treasurers ensured that no concerted policy was pursued and that Guy's remained a charity with urban responsibilities, but with an income dependent on the fortunes of agriculture. This accumulated financial problems for the future and encouraged a series of financial innovations discussed below.

Non-endowed hospitals did not hold such large amounts of land, but most continue to draw part of their income from rents:

Table 3.6: Income from Rents (percentage of total income).

Hospital	1850-1855	1870-1875	1890-1895
London Hospital	11.9	5.5	17.5
University College Hospital	-	-	1.6
Hospital for Sick Children	0.9	0.8	-
Royal Chest Hospital	3.3	0.5	-
German Hospital <sup>1</sup>	-	-	2.0

<sup>1</sup> For the German Hospital 1851 is the first available year for a breakdown of the hospital accounts. Source: Annual Reports 1850-1895.

The London, which mainly drew its income from invested property and subscriptions, however, did hold substantial estates in the East End. Houses were rented out and carefully maintained and from the 1880s onwards on average £4 per house was spent on renovations.<sup>90</sup> Rents varied, but when the governors redeveloped their property in New Panfelt Street, rent for a three-room tenement with scullery was set at 8s 6d per week.<sup>91</sup> The governors gradually increased the value of their holdings which generated a rental income of £2,229 0s 4d in 1850 (12.8% of the income for that year) rising to £8,933 5s 8d in 1895 (16.2% of income) as metropolitan land prices rose.<sup>92</sup> Most other non-endowed hospitals did not hold such extensive estates, but where property was

<sup>90</sup> M.Paton, 'Corporate East End Landlords - The Example of the London Hospital and the Mercers' Company', *London Journal*, 18 (1993), 117-8 which also discusses how the hospital managed its estates until the Second World War, representing a successful provider of working-class housing.

<sup>91</sup> LH Archive, Accounts Committee, A/9/4/1.

<sup>92</sup> London Hospital 1850 & 1895 Annual Reports.

held money raised from rent generally formed a small part of the income. The Middlesex avoided any investment in land, but still raised 9.5% of its income in 1890 from rents as the hospital had been left several properties.<sup>93</sup> At the Hospital for Sick Children rental income rose from £15 in 1853 to £195 13s 6d in 1875.<sup>94</sup> Property in the form of investments, however, represented an important source of funding. The governors of the Brompton Hospital felt by the 1880s that income from this source was the only ‘reliable’ form of funding.<sup>95</sup> Hospitals did not share the RSPCA’s hostility to ‘funded property’ and they looked on investments as a permanent source of revenue when other resources were essentially unreliable.<sup>96</sup>

Table 3.7: Income from Investments (percentage of total income).

Hospital	1850-1855	1870-1875	1890-1895
London Hospital	45.2	24.2	18.1
University College Hospital	0.5	14.4	12.4
Hospital for Sick Children	2.7	4.5	9.8
Royal Chest Hospital	24.7	5.6	1.3
German Hospital <sup>1</sup>	2.0	24.1	18.6

<sup>1</sup> For the German Hospital 1851 is the first available year for a breakdown of the hospital accounts. Source: Annual Reports 1850-1895.

A writer in the *Lancet* in 1886 recommended that hospitals should invest 75% of their income. Though this was impractical for many governors they did invest any surplus income, favouring government securities and profitable railway stock for their stability and interest rates.<sup>97</sup> A period of institutional stability at the Royal Chest Hospital in the early 1870s saw the governors investing most of the hospital’s legacies and large

<sup>93</sup> SC on Metropolitan Hospitals, 2nd Report, *PP* 1890/1 XIII, 123.

<sup>94</sup> GOS Archive, Committee of Management Minutes, 1/2/1-19.

<sup>95</sup> P.Bishop et al., *The Seven Ages of the Brompton* (Guildford, 1991), 68.

<sup>96</sup> B.Harrison, ‘Philanthropy and the Victorians’, *Victorian Studies*, 9 (1966), 366.

<sup>97</sup> *Lancet*, 1 (1886), 26.

donations, but by 1877 a deteriorating financial situation had ended this policy.<sup>98</sup> The governors of the German Hospital had always attempted to invest some of their annual income. However, the rebuilding of the hospital between 1863 and 1865 left a legacy of financial problems that saw the governors placing a new emphasis on investments when Baron Diegrad's gift of £10,000 in 1869 reversed the previous six years financial problems. A special subcommittee decided to invest £6,000 and in 1873 a firm decision was made to increase investments to prevent a further financial crisis.<sup>99</sup> The previous policy of investments was elevated into the hospital's main financial strategy, removing its reliance on, but not enthusiasm for philanthropy. The governors of the Hospital for Sick Children, after a period of uncertainty that lasted from 1852 to 1865, carefully managed their investments. With a preference for Indian Bonds, the governors increased the hospital's invested property when funds were available. Unprofitable stock was sold and the money raised was reinvested: in 1899 the governors sold £15,000 of Indian 3% stock for £15,898 5s 3d and used the money to buy securities that yielded a higher rate of interest.<sup>100</sup> The governors' provision of endowed beds was a move to attract legacies for investment purposes to increase the hospital's income. Other hospitals, on the advice of the *BMJ*, followed the Hospital for Sick Children's lead, but they needed little encouragement to invest surplus capital.<sup>101</sup>

The governors of the London modified the structure of their investments in 1863 in a move that introduced a new variant on invested income. To increase the hospital's income, the governors decided to reinvest some of the hospital's stock and use the income to provide mortgages that would yield a higher rate of interest. Initially £30,000 was allocated, but after two years of deliberation the House Committee, which was responsible for all the main decisions in the hospital's administration,

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<sup>98</sup> RCH Archive, Governors' Minutes, A1/4.

<sup>99</sup> GH Archive, General Court, A/4/2.

<sup>100</sup> GOS Archive, Financial Records, GOS/3/4/7.

<sup>101</sup> See page 65.



recommended that £100,000 should be reinvested.<sup>102</sup> The House Committee, however, could not act on its own recommendations because such a large change in the hospital's financial policy required the approval of a special meeting to which all the hospital's governors were invited. Legal advice was sought, a special governors' meeting was held and the House Committee was authorised to sell part of the hospital's securities for this purpose. In August 1865 the House Committee considered providing a mortgage of £95,000 for a property in Lincolnshire, but they did not act until December during which time the owner, Mr Augustine, was investigated. Once the investigation had been completed and the property was found to be worth £200,000 and have an annual income of £7,640 16s 4d, a mortgage of £100,000 was agreed at 4% (1% higher than most of the other investments).<sup>103</sup> The move represented the hospital's largest investment and at the time, with rising land prices and the hospital drawing approximately 10% of its income from property, the decision was a rational one given the hospital's incessant need for funds. Further mortgages were arranged, but by the late 1860s the initial enthusiasm had waned and invested property was increasingly sold to meet expenditure, leaving little room for further experimentation.<sup>104</sup> The governors' flirtation with lending on mortgage had ended with £182,750 tied up in land.<sup>105</sup> By the late 1880s, falling land prices strained repayment and in February 1897 it seemed that the hospital would lose the investment it had made in Augustine's property. After Sydney Holland, newly appointed as chairman, had instructed his solicitor to investigate, half the mortgage was repaid in September, followed by a further £18,000.<sup>106</sup> The governors had not recovered all their initial investment, but with interest repayments of approximately £4,250 a year they had raised £136,000 in interest alone on one mortgage. Between 1869 and 1874 mortgages provided 15.2% of the hospital's income, but when further mortgages were suggested in August 1897

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<sup>102</sup> LH Archive, Court Minutes, A/2/12.

<sup>103</sup> LH Archive, House Committee, A/5/32.

<sup>104</sup> LH Archive, House Committee, A/5/34-6.

<sup>105</sup> London Hospital 1875 Annual Report.

<sup>106</sup> LH Archive, House Committee, A/5/46.

no action was taken because problems with the Augustine property had made the governors cautious.<sup>107</sup> The governors had made a careful investment, but financial problems from the 1860s onwards prevented further mortgages and the policy was not adopted by other hospitals that lacked the London's invested income.

Property and investments not only provided a permanent source of funding, but at times of financial strain they were sold to provide an additional source of income. As *The Times* noted, property was drawn on 'without compunction in times of need'.<sup>108</sup>

Table 3.8: Income from Sale of Invested Property (percentage of total income).

Hospital	1850-1855	1863-1865	1870-1875	1890-1895
St.Bartholomew's Hospital <sup>1</sup>		11.0	12.8	4.5
University College Hospital	0.2		4.5	2.3
London Hospital	-		15.0	-
Royal Chest Hospital	-		0.6	0.1
Hospital for Sick Children	11.4		15.4	2.6
German Hospital <sup>2</sup>	1.6		13.6	0.1

Notes: <sup>1</sup> For St.Bartholomew's no account books exist for the period 1850-1855.

<sup>2</sup> For the German Hospital 1851 is the first available year for a breakdown of the hospital accounts.

Source: Annual Reports 1850-1895, SBH Archive, General Account Books, Hb/23/3-4.

Hamilton, author of the 1906 prize-winning essay, *The Economical Management of an Efficient Voluntary Hospital*, argued that this was a safer course of action than borrowing, but most contemporaries feared that it would damage hospitals' long-term financial positions. The governors of the Middlesex reversed their policy of selling their invested property in 1888, but most other governors periodically took part of their income from this source.<sup>109</sup> Governors remained careful, but a pressing need for funds overrode all concerns and they used their connections with London's financial centres

<sup>107</sup> LH Archive, House Committee, A/5/46.

<sup>108</sup> *Times*, 23 September 1871, 11.

<sup>109</sup> SC on Metropolitan Hospitals, 2nd Report, 128.

to good advantage and sought profitable deals.<sup>110</sup> The governors of the London could afford to sell some of the hospital's invested property because of the large amount it had invested. However, they were careful not to drain the hospital's resources too far and ultimately solicited money from direct philanthropy when the financial demands of medical care in the East End became too great.<sup>111</sup> Other hospitals had to be more cautious, but institutions like St.Bartholomew's, the Hospital for Sick Children, and the German Hospital, for all their careful management had to sell small amounts of their invested property to avoid annual deficits.

Investments were sold for two reasons: to fund the hospital's expansion, or to meet a deficit. The provision of new wards and clinical facilities imposed a considerable strain on hospital finance. At the German Hospital, £5,500 in London & North Western Railway Debentures had to be sold in 1868 to meet the debts incurred in building; in 1898 £2,700 in Great Eastern Railway Debentures were sold for the same purpose.<sup>112</sup> The short-term nature of these actions is shown by one of the hospital's rules that required that all amounts sold had to be reinvested when funds permitted.<sup>113</sup> Generally governors found it easier to accept the sale of stock when it was used to meet building costs. Suggestions made by the Governors' Committee at the Royal Chest Hospital in 1879 to sell £3,000 in 3% consols to purchase the hospital's freehold met approval, but in 1889 those governors not involved in the hospital's immediate management resisted the sale of £6,000 in consols as they wanted the matter investigated to see why this move was necessary.<sup>114</sup> Pressure on the hospital's funds, however, saw the governors selling invested property to balance the books rather than fund expansion. Other hospitals were equally motivated by financial necessity at different points in their institutional history, but all were affected by the

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<sup>110</sup> See Chapter 5.

<sup>111</sup> LH Archive, House Committee, A/5/38-39.

<sup>112</sup> GH Archive, Hospital Committee, A/2/4; A/2/10.

<sup>113</sup> GH Archive, General Court, A/4/1.

<sup>114</sup> RCH Archive, Court Minutes, A2/1.

fact that income from the benevolent economy was not always available to meet their needs.

Land and investments, however, were not just sold to raise additional capital, but also for sound financial reasons. The governors of the German Hospital prudently reinvested their holdings in Europe in 1875 during the Russo-Turkish war as they feared that interest rates would fall.<sup>115</sup> The governors of the London similarly practised a careful investment policy. St.Bartholomew's, as a major landowner, had to adopt a commercial approach to its investments. By 1891 the property St.Bartholomew's held in Essex was considered almost worthless; two farms were empty and when 268 acres were sold for £2,000 the governors were 'glad to get the money'.<sup>116</sup> A small plot of land was also sold to the North London Railway Company, but the move made economic sense as the company paid £20,000, a figure greater than its potential rental income.<sup>117</sup> Governors, with the aim of maximising their hospital's income, could not afford to miss such opportunities, especially if it meant disposing of an asset that could prove a liability.

Land and investments were not the only potential sources of income from the sale of the hospital's property. The *Hospital* believed that money from kitchen waste was 'worth the collecting' as for every 100 inpatients £30 to £50 per annum could be raised.<sup>118</sup> The sale of waste material, particularly kitchen scraps, rarely amounted to more than 1% of the hospitals' income, but it was a permanent and unglamorous feature of hospital finance that attracted little attention. More controversial was the sale of resources derived from the hospitals' function as a medical institution. Hospitals offered a number of services to their patients, medical students and the public that could be used to raised money. The Royal Chest Hospital regularly sold its list of subscribers' names to other institutions as well as copies of the hospital's *Pharmacopoeia* to doctors and respirators to patients. The amounts raised were

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<sup>115</sup> GH Archive, Hospital Committee, A/2/6.

<sup>116</sup> SC on Metropolitan Hospitals, 2nd Report, 34.

<sup>117</sup> SBH Archive, Governors' Minutes, Ha/1/21.

<sup>118</sup> *Hospital*, 21 November 1896, 134.

invariably small: in 1889 the sale of respirators made 8d. while the *Pharmacopoeia* raised £1 10s 8d.<sup>119</sup> Amounts of this size did little for the hospital's total income, but it showed an enterprising spirit that was repeated elsewhere. Guy's offered a unique service. In 1894 a scheme was set up where for a charge of 10s 6d the hospital would find a locum.<sup>120</sup> The Royal Chest Hospital hired out bath chairs, while University College Hospital opened its baths to the public in 1871, a late attempt to capitalise on the move to found public baths in London in the 1860s.<sup>121</sup> Other hospitals preferred to raise income more directly from the clinical services they dispensed, making money out of something they had to provide.

Patients were an obvious source of income and it was here that the hospitals' philanthropic credentials came into conflict with their financial needs. Three schemes could be adopted: charges for medicines could be introduced, small fees for outpatient attendance adopted, and paying inpatients admitted. The last measure was the most ambitious and expensive because a higher quality of non-medical care linked to privacy had to be established. Granshaw has argued that this admission of paying patients was partly a response to concerns over charitable abuse.<sup>122</sup> The debate over the abuse of hospital outpatients' departments, where an increase in patient numbers was misconceived as an increase in 'undeserving' cases, formed the background for the discussion of the provident principle and the admission of paying patients. Where it was felt that patients were abusing the hospital, payment was rationalised as a system for preventing abuse without reducing admissions. Contribution schemes were well established in Europe and America where it was argued that they strengthened the national character of independence, but in England practical schemes took longer to emerge. In 1856 Guy, a physician at King's College Hospital, had first recommended an outpatients' payment scheme because he was convinced that many patients could

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<sup>119</sup> RCH Archive, Finance Committee, A5/1.

<sup>120</sup> *Lancet*, 1 (1894), 438.

<sup>121</sup> RCH Archive, Finance Committee, A5/2; A.S.Wohl, *Endanger Lives: Public Health in Victorian Britain* (1984), 73-6.

<sup>122</sup> L.Granshaw, 'St.Thomas's Hospital, London 1850-1900' (Unpublished PhD Thesis, Bryn Mawr College, 1981), 373-423.

afford to pay something for their treatment.<sup>123</sup> A similar view was adopted by the governors of the Hospital for Sick Children in 1860, but no plans were made to put the scheme into practice.<sup>124</sup> However, other influences linked to the demand for institutional care for the middle classes can be detected. Southwood Smith had endorsed a programme in 1842 to open a hospital for the middle classes in London, but it failed after three years through lack of support. The notion received further backing from Burdett in the 1870s through his Home Hospital Association that established a Home Hospital in London in 1880. It was an attempt to offer hospital treatment in a homelike atmosphere as a practical convenience for patient and doctor and an alternative to the unsuitable nature of normal lodgings for sophisticated medical treatment. Cottage hospitals developed the same principles. The pay principle was implicit and the Association endeavoured to promote the contributory system.<sup>125</sup> The extent of the Association's influence is uncertain, but by 1883 34 hospitals were charging their patients.<sup>126</sup>

Informal patient charges, however, already existed at many hospitals. With the creation of the New Poor Law in 1834, a network of local unions were established, but many were unable to treat all the cases of sickness that applied for relief. To overcome this problem local unions sent some of their patients to the voluntary hospitals, creating an 'internal market' between healthcare sectors. Steele, the medical superintendent at Guy's, noted in 1882 that 'from time immemorial, it has been the custom for guardians in London, as well as in the country, to send special cases to the hospital for the benefit of the superior medical skill and treatment it affords'.<sup>127</sup> Marland's work on Wakefield and Huddersfield suggests that this was not limited to London.<sup>128</sup> Most paupers were admitted under subscription rights, but hospitals that

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<sup>123</sup> Cited in Granshaw, 'St.Thomas's', 386.

<sup>124</sup> GOS Archive, Medical Committee, GOS/1/5/2.

<sup>125</sup> *BMJ*, 2 (1878), 806.

<sup>126</sup> J.L.Clifford-Smith (ed.), *Hospital Management* (1883), 52-3.

<sup>127</sup> *BMJ*, 2 (1882), 805-6.

<sup>128</sup> Marland, *Medicine and Society*, 84-5.

relieved a large number of Poor-law patients established a system of charges that were represented as a separate source of income in the accounts:

Table 3.9: Income from Poor-law patients (percentage of total income).

Hospital	1850-1855	1870-1875	1890-1895
University College Hospital	-	0.5	0.01
Guy's	0.2	0.4	0.2
London Hospital	0.3	0.6	0.4

Source: Annual Reports 1850-1895; Guy's Archive, Financial Abstracts, D19/1-3, A94/1.

Charges were small. At Guy's, Poor-law patients were admitted at 1s. per day, but this was too high for St.Saviour's Union that complained about the charges in 1882.<sup>129</sup> St.Pancras Union contributed fifty guineas annually to University College Hospital and agreed to pay 10s. per patient per week for each additional patient, and in 1866 20 beds were allocated to the Union on a semi-permanent basis.<sup>130</sup> A transfer of cost between voluntary hospitals and Poor-law institutions, however, remained limited to the large general hospitals, located near densely populated areas.

Payment schemes that were not connected to the Poor Law, attracted staunch opposition and were seen as the 'modern philanthropy of commerce'.<sup>131</sup> Opposition focused on four main points: payment, it was feared, would encourage subscribers to withdraw their support, discourage patients and deprive hospitals of clinical material, and represent a break with the hospitals' charitable nature. The BMA remained critical, believing that payment would damage the economic position of general practitioners, a view shared by many general practitioners who felt that it would reduce the medical profession to a trade and create unfair competition.<sup>132</sup> For the COS, any

<sup>129</sup> Guy's Archive, Court Minutes, A3/10.

<sup>130</sup> UCH Archive, General Committee, A1/2/1-2.

<sup>131</sup> *Nineteenth Century*, 32 (1892), 299.

<sup>132</sup> *Charity Organisation Review*, (1886); *Lancet*, 1 (1884), 363.

hospital payment scheme would paradoxically limit providence and prevent the development of character by creating the notion that nominal payment gave a right to charitable relief.<sup>133</sup> One speaker at a conference of hospital administrators organised by the Social Science Association in 1882 believed that ‘even the bankrupt condition of a hospital is not sufficient to justify its committee in beginning to trade in medical relief’.<sup>134</sup> Criticism, however, did not dissuade several hospitals from admitting paying patients, and other writers stressed the financial background behind their controversial decisions. One writer in *The Times* in 1882 recommended payment by patients as the best way to provide additional funds for the London hospitals, a view shared by Burdett.<sup>135</sup> The *Charity Record & Philanthropic News* reluctantly advocated the pay system as a possible solution to the metropolitan hospitals’ financial problems. The journal provided a moral gloss to make its suggestion more palatable, noting that it would remove the ‘semi-pauperism’ that hospitals encouraged.<sup>136</sup> As the initial hope that paying patients would bring vital income into the hospital faded with experience, paying patients were made to serve another purpose. Image and utility were crucial in London’s highly competitive benevolent economy, for a closed bed created an unfavourable impression and reduced the number of patients that could be treated. A paying bed, however, provided additional income and ensured that beds were kept open, increasing admissions.

Individual hospitals did not rationalise their moves to charge patients, but admitted them to provide a new source of funding. At the Poplar Hospital a 4d. outpatients’ charge was introduced soon after the hospital opened because it faced mounting debts.<sup>137</sup> St.Thomas’s adopted a similar course on financial grounds.

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<sup>133</sup> C.S.Loch, ‘Confusion in Medical Charities’, *Nineteenth Century*, 32 (1892), 306.

<sup>134</sup> Cited in Clifford-Smith, *Hospital Management*, 46.

<sup>135</sup> *Times*, 14 June 1882, 7; 15 January 1883, 12.

<sup>136</sup> *Charity Record & Philanthropic News*, 3 (1883), 233.

<sup>137</sup> N.Barnes, ‘The Docker’s Hospital’ (Unpublished BSc. Dissertation, Wellcome Institute Library, 1993).



Whether a hospital decided to charge its patients depended on its nature, its financial situation, and on what types of patient it treated:

Table 3.10: Patient Payment by Hospital Type (1897).

Hospital Type	Number	Inpatients	Outpatients
General	28	£6,337	£1,906
Chest	7	£4,179	-
Children's	14	£2,074	£1,111
Lying-in	6	£335	£619
Women's	7	£1,652	£1,383
Fever	1	£2,384	-
Lock	2	£2,514	£1,444
Dental	2	-	£1,391
Epilepsy	4	£2,511	£894
Fistula	2	£685	£89
Ophthalmic	5	£538	£512
Orthopaedic	3	£1,532	-
Skin	4	£451	£3,667
Stone	1	£181	£2,057
Throat	5	£735	£4,895
Cottage	5	£394	-

Source: *Hospital Saturday Fund Journal*, September 1897, 4.

Specialist hospitals were believed to charge most of their patients and a report by the Hospital Association in 1897 noted that they were 'largely dependent on the payment of patients' for their income. Of the 41 specialist hospitals in 1895, 73% charged for treatment, though few drew as much income from this source as the Grosvenor Hospital for Women and Children where money from patients represented one third of the hospital's total income.<sup>138</sup> Payment schemes, however, were less widespread in

<sup>138</sup> *Hospital*, 31 December 1887, 236; *Lancet*, 1 (1897), 1031.

general hospitals, despite a rising demand from middle-class patients for institutional medical care. St.Thomas's was the first major hospital to admit paying patients. Its decision pushed the issue before the public and involved the hospital in an internal struggle between the governors and the less enthusiastic medical staff that lasted from 1878 to 1881.<sup>139</sup> The impetus came from the hospital's financial position. The long-term expenditure involved in its move to Lambeth acted as a continuous drain on the hospital's endowed income and imposed higher running expenses. Rents for landed property and donations did not increase as expected, the former declining with the agricultural depression.<sup>140</sup> Tired of St.Thomas's incessant financial problems, the Charity Commission suggested a payment scheme, which after lengthy discussion was adopted.<sup>141</sup> The medical journals approved of the idea but disliked the scheme, and the *Lancet* condemned the governors' dismissive attitude to the medical staff.<sup>142</sup> On 1 March 1881 the hospital was opened to paying patients. Over the next nine months a total of 237 patients were admitted, producing a profit of £400, but from 1886 admissions declined and the scheme was not the success that the treasurer had envisaged.<sup>143</sup>

The governors of the London did discuss an outpatient payment scheme in 1880, but it was Guy's that initially followed St.Thomas's lead.<sup>144</sup> In 1883 Guy's admitted its first paying patient after it had suffered four years of intense financial problems linked to falling rental income from the impact of the agricultural depression. Once more the Charity Commission, reluctant to sanction further loans, had taken the initiative and suggested the admission of paying patients. With few other alternatives available the governors were forced to following the Commission's proposals.<sup>145</sup> There

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<sup>139</sup> Granshaw, 'St.Thomas's', 401-419.

<sup>140</sup> Granshaw, 'St.Thomas's', 390-393.

<sup>141</sup> See note 31 for a discussion of the Commission's influence.

<sup>142</sup> *Lancet*, 1 (1880), 19.

<sup>143</sup> Granshaw, 'St.Thomas's', 421.

<sup>144</sup> LH Archive, House Committee, A/5/39-40.

<sup>145</sup> Guy's Archive, Letters to the Charity Commission, A172/2.

was little internal discussion and two schemes were adopted. The governors suggested that patients could be admitted to the wards under two forms of payment: the first admitted them to the general wards at a cost of one guinea per week, the second was a three-guinea fee for admission to a separate paying ward of 12 beds. The three-guinea charge bought nursing care, rudimentary medical care from a Resident Medical Officer, and a separate cubicle. All treatment had to be negotiated with the medical staff or with an approved hospital consultant; general practitioners were excluded.<sup>146</sup> Initially 38 beds were allocated rising to 50 in 1886.<sup>147</sup> The medical staff suggested the second method of payment. A 3d. outpatients' fee was to be levied on the patient's second visit, allowing the staff to administer free emergency medical care. A clear statement of an inability to pay by a doctor, priest, or the COS granted free treatment. It was felt that this would have a less damaging effect on the number of patients admitted and allow doctors to give emergency treatment, but would remove unnecessary or trivial cases. In a Finance Committee memorandum in 1897 it was stated that 'the paying patient system was... originally a temporary measure expedient to raise money...', but as income did not improve it became permanent.<sup>148</sup> The low number of patients admitted in the first few months encouraged the view that the scheme was a failure, but it was not abandoned as the governors and staff anticipated that reforms would make the scheme more attractive.<sup>149</sup> By 1890 improvements in the paying ward ensured that admissions rose and the initial hopes were justified.

The German Hospital, unlike many other general hospitals, had always admitted paying patients through its separate Sanatorium. The aim was to provide treatment for members of the respectable working and middle classes who could not be nursed at home. The institution remained small, admitting only German natives or German

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<sup>146</sup> Guy's Archive, Court Minutes, A3/11.

<sup>147</sup> Guy's Archive, Memorandum Book, A164/1.

<sup>148</sup> Guy's Archive, Finance Committee, A24/1.

<sup>149</sup> Guy's Archive, Medical Committee, A20/1.

speaking patients and charging them on a sliding scale.<sup>150</sup> Payment was linked to the type of room, not the treatment required, though from 1857 syphilitic patients were charged at one guinea higher than the other patients to bring admissions in line with costs and to discourage such patients.<sup>151</sup> The Sanatorium was a service for those who could afford to pay, removing all concerns over hospital abuse. It represented a ‘highly important branch’ of the hospital, but it received few patients and made little money.<sup>152</sup>

Income from patients could not solve the London hospitals’ incessant need for funds in the short or long term. After a slow start at Guy’s the income from paying patients did gradually rise:

Table 3.11: Guy’s: Payments from Inpatients.

Year	Paying Ward		Other Wards		Outpatients	
	no.	receipts	no.	receipts	no.	receipts
1886	77	£721 10s 7d	262	£1038 18s 0d	63,077	£715 5s 2d
1887	84	£702 10s 2d	311	£1467 12s 10d	56,353	£656 0s 7d
1888	81	£889 5s 0d	333	£1245 14s 0d	59,175	£670 12s 0d
1889	89	£1093 6s 0d	283	£984 14s 0d	53,885	£631 7s 0d
1890	183	£1672 14s 6d	284	£1077 2s 0d	57,412	£657 9s 5d
1891	196	£2221 6s 0d	273	£1030 3s 6d	62,621	£750 16s 4d
1892	224	£2326 13s 0d	316	£1091 19s 11d	63,335	£730 16s 4d
1893	216	£2091 7s 0d	279	£867 1s 1d	64,656	£752 8s 1d
1894	208	£2300 0s 4d	641	£1211 15s 0d	68,945	£807 3s 1d
1895	216	£2718 2s 6d	301	£1247 10s 0d	76,109	£874 15s 11
1896	301	£2502 17s 6d	321	£1289 9s 0d	78,762	£920 0s 0d
1897	277	£2505 17s 6d	298	£955 17s 6d	80,265	£941 6s 1d
1898	353	£3120 7s 0d	16	£87 3s 0d	80,862	£956 6s 7d

Source: Guy’s Archive, Treasurer’s Reports, A94/1-2.

<sup>150</sup> This did not absolutely preclude the admission of English patients as exceptions were made.

<sup>151</sup> GH Archive, Hospital Committee, A/2/2.

<sup>152</sup> *Charity*, June 1887, 5.

According to the *Hospital* in 1890, payment schemes provided 15% of provincial hospitals' income, but Burdett estimated in 1893 that patient charges in London produced only 2% of the total income of London's general hospitals and 7.5% for specialist hospitals.<sup>153</sup> The difference reflected the number of general hospitals in London prepared to admit paying patients. At the German Hospital payment from patients remained marginal, contributing 1.9% between 1850 and 1854, and 2.7% between 1890 and 1895.<sup>154</sup> Profits were never substantial and payment was never in proportion to the cost of treatment. At Guy's in 1886-7 84 paying inpatients produced a profit of only £103 10s 1d; by 1890-1 this had risen to 187 patients with a profit of £850 4s 4d.<sup>155</sup> However, there was an immediate effect on the number of cases treated. Outpatient admissions at St. Thomas's and Guy's, despite the optimism of the *BMJ*, fell dramatically when payment was introduced and only slowly recovered.<sup>156</sup> The hope of long-term profits had to be balanced against the immediate fall in admissions that threatened the hospital's appearance of utility, and the small amount of income that paying patients generated.

Patients were not the only recipients of the hospital's services who were charged. Nurses had to pay for their training. According to Dingwall *et al.*, the hospitals' precarious financial situation forced governors to economise. To save money they discontinued their employment of nursing sisterhoods, who provided a semblance of professional nursing and an occupation for middle-class women within a quasi-religious body, and established their own nursing schools to provide cheap nursing labour.<sup>157</sup> Though this might be an exaggeration, the growth of a body of trained

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<sup>153</sup> *Hospital*, 26 April 1890, 47; H.C. Burdett, *Hospitals and Asylums of the World* (1893), 119.

<sup>154</sup> German Hospital Annual Reports, 1850-1895.

<sup>155</sup> Guy's Archive, Reports of Superintendence, A67/7-8.

<sup>156</sup> *BMJ*, 1 (1884), 184.

<sup>157</sup> P. Dingwall *et al.*, *An Introduction to the Social History of Nursing* (1988), 59; see J. Moore, *A Zeal for Responsibility* (1988); A. Summers, 'The Mysterious Demise of Sarah Gamp: The Domiciliary Nurse and her Detractors', *Victorian Studies*, 32 (1988/89) and C. Helmstadter, 'Robert Bentley Todd, St John's House and the Origins of the Modern Trained Nurse', *Bulletin of the History of Medicine*, 67 (1993) for a discussion of the role

nurses had economic benefits for the hospital, though at the same time placed a burden on the hospital's running costs.<sup>158</sup> Not all hospital types benefited: training schools were generally established only at the general teaching hospitals, working in tandem with the medical college. St.Thomas's, with the foundation of the Nightingale School in 1860, set the pace. By the 1870s most general hospitals, except St.Mary's, claimed to train nurses, though a survey in 1875 by Florence Lee, a Nightingale nurse, found little systematic training.<sup>159</sup> Among the specialist hospitals, the Hospital for Sick Children proved an exception. It had been Charles West's wish that the hospital would train nurses specifically for the care of children, though a training school was not formally established.<sup>160</sup> Nursing schools developed at a slower rate. In 1877 St.Bartholomew's established a school with two members of the medical staff as instructors and the London followed in 1880, though nurses' accommodation was not opened until 1886.<sup>161</sup>

Training schools did place a burden on expenditure, contrary to Witz's assessment, but probationary nurses provided a cheap source of nursing labour, while they could be used to perform other domestic duties.<sup>162</sup> Nurses equally promoted efficient patient care that meant more patients could be treated, increasing individual hospitals' claims to utility. The benefits extended beyond this. Hospitals, in establishing nursing schools, charged probationers for their training, adding an additional source of income. It must be doubted whether this covered the cost of training and accommodation, but it went some way towards making this new function self-funding. Invariably nursing agencies were established through these training schools, placing nurses in private work. The client paid the hospital who then paid the nurse a fixed annual salary. The London had 100 private nurses on duty by 1899,

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of the nursing sisterhoods.

<sup>158</sup> See Chapter 4.

<sup>159</sup> G.Rivett, *The Development of the London Hospital System: 1832-1982* (1986), 103-4.

<sup>160</sup> GOS Archive, Letters, GOS/8/151.

<sup>161</sup> LH Archive, House Committee, A/5/40; House Committee, A/5/42.

<sup>162</sup> A.Witz, *Professions and Patriarchy* (1992), 137.

charging £2 2s per day for ‘ordinary cases’, £1 1s for attendance at an operation, and 10s 6d per visit for leeching.<sup>163</sup> By 1905 over half the general hospitals in England and Wales hired out private nurses and until 1914 private nurses made up three quarters of the nursing labour market.<sup>164</sup> Such operations, after an initial investment had been made in the nurses’ education, were more lucrative. By 1891 income from nurses represented 2.5% of the national hospital income and acted as a ‘modest but reliable source of income’.<sup>165</sup> This overall figure obscures the benefit to individual hospitals:

Table 3.12: Income from Nursing (percentage of total income).

Hospital	1870-1875	1890-1895
London Hospital	-	4.3
Hospital for Sick Children	0.6	5.5
St.Bartholomew’s	-	1.8
Guy’s	-	2.6

Source: Annual Reports 1850-1895; Guy’s Archive, Financial Abstracts, D19/1-3, Treasurer’s Reports, A94/1; SBH Archive, General Account Books, Hb/23/3-4.

Teaching hospitals in London, with a greater market for medical care and a reputation for excellence, derived more benefit from nursing than the provincial hospitals. Steele noted, however, that generally ‘nurses earn good round sums for the Hospital’.<sup>166</sup>

All medical schools charged their students tuition fees. The money was divided between the doctors who taught there and, because medical schools did not generally receive any large financial assistance from the hospitals to which they were attached, the medical school’s running expenses. Nelson Hardy, a prominent hospital reformer, argued that medical schools should be entirely self-funded.<sup>167</sup> However, where most teaching hospitals had a symbiotic relationship with their medical schools based on

<sup>163</sup> London Hospital 1899 Annual Report, 14.

<sup>164</sup> C.J.Maggs, *The Origins of General Nursing* (1983), 131.

<sup>165</sup> Dingwall et al, *Social History of Nursing*, 59.

<sup>166</sup> *Charity Record & Philanthropic News*, 11 (1891), 25.

<sup>167</sup> H.Nelson Hardy, *London Hospitals and the Jubilee* (1897), 49.

mutual service, University College Hospital used tuition fees as a general source of income. Fees were paid straight to the doctors and University, and both voluntarily redirected their share back to the hospital, but this was not recorded as a donation as neither body made any attempt to collect their fees. In the first three decades after the hospital opened, fees formed an important part of its income: between 1850 and 1855 they represented 30.8% of its funding. However, by the end of the nineteenth century the level of fees redirected to the hospital had halved and their significance in the structure of income had declined as income from other sources increased, so that between 1890 and 1895 fees represented 4.1% of income.<sup>168</sup> Where fees had provided the second largest component of income (after donations) in the 1850s, by the 1890s they ranked eighth. However, the governors continued to regard them as an important source of funding and were concerned to maintain the reputation of the hospital's medical school to keep the number of fee-paying students up.

When all other sources of funding left a deficit, governors borrowed to circumvent financial problems, keep beds open, pay tradesmen's bills, and pay for new wards or clinical facilities:

Table 3.13: Income from Loans (percentage of total income).

Hospital	1850-1855	1870-1875	1890-1895
London Hospital	4.8	-	-
University College Hospital	6.3	2.49	9.38
Hospital for Sick Children	-	1.8	5.2
St.Bartholomew's	-	14.6	2.5
German Hospital <sup>1</sup>	11.6	1.9	7.2

<sup>1</sup> For the German Hospital 1851 is the first year records are available

Source: Annual Reports 1850-1895, SBH Archive, General Account Books, Hb/23/3-4

Borrowing was a short-term and a long-term strategy and at certain periods all hospitals sought loans, though some with more frequency than others. Governors were prepared to borrow large amounts to balance the books and meet what was considered

<sup>168</sup> UCH Annual Reports, 1850-1895.



‘extraordinary’ expenditure (see appendix). The *Charity Record & Philanthropic News* complained that loans were an expensive way of raising money, but noted that they were often essential in keeping hospitals running.<sup>169</sup> The governors of University College Hospital and the London used loans as a first resort to meet any deficit. At the London a policy of loans joined with the sale of stock kept the hospital open and matched the demands placed on it that the benevolent resources available within the local community could not afford to meet. Between 1850 and 1860, the governors borrowed a total of £14,000, most of which was repaid from the sale of invested property.<sup>170</sup> University College Hospital even borrowed money from the University to pay back the banks that had lent it money.<sup>171</sup> The endowed hospitals had to have the Charity Commission approve every loan they took out, but this did not dissuade them from borrowing and even St.Bartholomew’s borrowed money, though for improvements rather than debt.

Loans were sought from several sources. In the first few years after an institution’s foundation, small amounts were borrowed from the treasurer, a policy adopted by the Hospital for Sick Children until the 1870s to avoid the impression that it was in debt. Money could also be borrowed internally when resources were transferred between the building fund and the general fund. In 1883 the Royal Chest Hospital had to ‘borrow’ £700 from its building fund to cover expenditure because donations had fallen.<sup>172</sup> It was a move the governors repeated frequently, though such a policy ensured that building work was delayed. Other hospitals established deposit accounts for this purpose. Internal borrowing was unreliable and represented an internal transfer of funds rather than a real debt. As the demands of an institution grew and new wards were built or sanitary improvements undertaken, internal borrowing became insufficient and governors turned to banks and building societies for money. When the builders at the German Hospital refused to extend the governors’ credit in

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<sup>169</sup> *Charity Record & Philanthropic News*, 6 (1886), 103.

<sup>170</sup> LH Archive, House Committee, A/5/27-30.

<sup>171</sup> UCH Archive, Medical Committee, A1/1/2.

<sup>172</sup> RCH Archive, Annual Reports, A8/6.

1868, £1,500 immediately had to be borrowed from a bank.<sup>173</sup> Loans may have been seen as an ideal solution to periodic financial difficulties, but extensive borrowing created problems for individual hospital's finances. The Charity Commission was aware of these problems when they refused to sanction further loans for St.Thomas's and Guy's in the 1880s. They informed the governors at Guy's in 1886 that

while ready and anxious to assist the Governors in the administration of the Hospital in the present critical condition of its finances, [the commission] must yet remind them that the repeated recourse to loans... will obviously lead at no distant date to a condition of absolute insolvency...

The Commission stressed the need to develop other sources of funding and adopt a better system of financial management to prevent such situations occurring.<sup>174</sup> The governors were appalled, but they could do little but follow the Commission's suggestions. Other hospital governors, without an external regulation on their borrowing, were aware that there was a limit to borrowing and at least attempted to repay all loans when money was available to prevent such problems from arising. However, considering the widespread level of borrowing, it should not be surprising that many hospitals faced financial problems by the 1890s that their deficit financing could not overcome.

Hospital finance was multifaceted and erratic, conditioned by the resources available within the benevolent economy, but at the same time able to draw on a wider number of resources linked to the hospital's function and property. Hospitals as charitable institutions could not rely on charity for all their financial needs. The parameters of hospital funding seemed broad, but the structure of finance was forced to change as the hospital developed and assumed more medical functions.

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<sup>173</sup> GH Archive, House Committee, A/2/4.

<sup>174</sup> Guy's Archive, Letters from the Charity Commission, A118/20.

## 5. CHANGING PATTERNS OF HOSPITAL FINANCE: FINANCIAL DIVERSIFICATION

Hospital finance, even in 1850, was not in 'that flourishing condition... which everyone would wish'.<sup>175</sup> In the pursuit of financial security and from a desire to balance the books, governors gradually and erratically adapted the structure of their hospital's income. A change in the nature of the hospital required an alteration in the hospital's finances and governors, often preoccupied with financial concerns, responded in the face of change. Hospitals were a flexible enough institution to adapt to new financial demands and conditions, though change was rarely immediate and often the result of crisis management and opportunity. The result was an uncoordinated process of financial diversification.

Financial diversification took several forms. Existing sources of funding could be modified. For example, the London's move to reinvest its government bonds in mortgages was an attempt to increase income that simultaneously modified an existing resource. Income from direct philanthropy was changed in a similar manner as new means of attracting charitable funds were adopted or old ones declined in importance. Financial diversification was also ensured by the development of existing resources so that they changed their relative importance within the structure of income. The governors at the German Hospital achieved this after 1869 by placing a renewed emphasis on investments. Diversification could also mean the development of new sources of funding. The foundation of the Sunday Fund and Saturday Fund in the early 1870s promoted financial diversification. They created a new channel for voluntary contributions through indirect philanthropy that benefited London's non-endowed hospitals and increased the money they received from the benevolent economy. Other London hospitals made existing services into a financial asset and attempted to make new services self-funding. New financial strategies did not have to be grand to modify the hospital's structure of income.

All hospitals, to one degree or another, experienced a process of financial diversification. In the 1850s University College Hospital had nine main sources of

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<sup>175</sup> *Medical Times & Gazette*, 21 (1850), 10.

income, by the 1890s it had 16; at the Royal Chest Hospital the number rose from seven to ten, and from nine to 17 at the Hospital for Sick Children. The different approaches to diversification can be seen at the German Hospital, St.Bartholomew's and Guy's. The German Hospital displayed a pattern of diversification that reflected a process of crisis management in the 1860s, followed by a period in which the governors built up the hospital's investments to increase its 'reliable' income. In the 1850s, the hospital relied on ten main sources of funding, by the 1890s this had risen to 14:

Table 3.14: German Hospital: Income 1851-1895 (per cent).

		1851-1855	1870-1875	1890-1895
Balance		8.4	4.1	1.6
Direct Philanthropy:	Subscriptions	23.5	13.2	18.0
	Donations	39.9	37.4	34.4
	Legacies	2.1	2.5	6.3
	Collections	8.3	0.2	0.5
Indirect Philanthropy:	Sunday Fund	-	1.9	6.1
	Saturday Fund	-	0.4	1.8
Hospital's Property:	Dividends	2.0	13.8	18.6
	Deposit	-	8.5	-
	Rent	-	-	2.0
	Sale of Stock	1.6	13.6	0.1
	Insurance	0.7	-	-
	Tax Redeemed	-	0.1	0.5
Hospital's Function:	Patients	1.9	2.1	2.7
Loans		11.6	1.9	7.2
'Sundries'		-	0.3	0.2

Source: Annual Reports 1850-1895.

Until the late 1870s the experience of financial diversification at the endowed hospitals was less acute. St.Bartholomew's remained dependent on rental income, but this did not stop the governors from utilising other sources of funding. In the 1850s St.Bartholomew's drew its income from 16 sources of funding, by the 1890s 20 sources were being used. Income from the hospital's landed estates could not meet all its financial needs:

Table 3.15: St.Bartholomew's: Income 1863-1895 (per cent).

		1863-1865	1870-1875	1890-95
Balance		7	1.1	3.7
Direct Philanthropy:	Donations	1.5	0.9	0.5
	Legacies	0.2	2.1	2.7
Hospital's Property:	Rent	77.7	56.2	73.2
	Tithes	0.4	0.1	2.0
	Dividends	10.2	7.9	4.2
	Sale of Waste	0.5	0.3	-
	Sale of Property	-	12.8	4.5
	Tax Redeemed	0.8	1.3	2.0
	Insurance	-	1.8	2.0
Hospital's Function:	College	0.1	0.1	0.8
	Nursing	-	-	1.8
Loans		-	14.6	2.5
Sundries		1.6	0.8	0.1

Source: SBH Archive, General Account Books, Hb/23/3-4.

Financial diversification at St.Bartholomew's was not the product of an anxious pursuit of funds, rather a response to new financial opportunities and demands. At Guy's the situation was different and diversification was a lesson in crisis management after the hospital's income had been dramatically affected by the agricultural depression:

Table 3.16: Guy's: Income 1853-1895 (per cent).

		1853-1855	1870-1875	1890-1895
Direct Philanthropy:	Donations	0.4	0.2	23.0
	Legacies	-	2.1	-
Indirect Philanthropy:	Sunday Fund	-	-	1.0
	Saturday Fund	-	-	1.2
Hospital's Property:	Rent	95.6	95.8	58.2
	Dividends	3.8	1.5	4.2
	Sale of Property	-	-	0.1
Hospital's Function:	Nursing	-	-	2.6
	Patients	0.2	0.4	9.7

Source: Guy's Archive, Financial Abstracts, D19/1-3; Treasurer's Reports, A94/1.

Each hospital had its own financial approach and response to financial problems. The German Hospital displayed a careful and at times cautious financial policy where diversification was a consequence of an attempt to meet the hospital's running costs and the financial strain of rebuilding. The Hospital for Sick Children and the London had a similar approach to their finances, where Guy's and University College Hospital, if not reckless, were not as careful in their administration, producing an impression of crisis management. The result, however, was the same. Each hospital in London, and to a lesser extent each hospital in England, underwent a process of financial change as it evolved and aged. Governors, in their pursuit of new sources of funding, unconsciously and erratically diluted charity's financial contribution to the hospital. However, if common sources of income can be found in the internal economy of hospital finance, it might also be possible to identify common factors that encouraged this widespread, if not uniform, process of financial diversification. It is the explanation of these changes that the next chapter addresses.

## Financial Diversification - An Explanation

Financial diversification was not a random phenomenon. All London hospitals changed the structure, and sometimes the nature of their income. It was a process that accelerated from the 1860s onwards as hospitals increasingly faced a financial crisis that dogged them until the foundation of the NHS in 1948. Governors responded to the endemic financial crisis by expanding the number of sources from which they drew their income. However, there was more to the process of diversification than a deepening financial crisis.

Contemporaries were pessimistic about the hospitals' economic fortunes, but few analysed the reasons behind their apparent crisis. In a speech in favour of the Sunday Fund in 1887, Baron Ferdinand de Rothschild provided a rare analysis of the factors that influenced hospital finance. He identified the agricultural depression, competition within the benevolent economy, the growth of specialist hospitals, and a disregard for physical ailments as the main reasons for the hospitals' misfortunes.<sup>1</sup> Others blamed the 'widespread and just dissatisfaction' with the administration of medical charities or the lack of cooperation between the medical and philanthropic sides of the hospital.<sup>2</sup> Governors, however, did not acknowledge these influences, merely lamented their problems and directed their efforts into fundraising. Any interpretation of financial diversification therefore has to reconcile the pressures exerted on the hospitals' finances with the hospitals' experiences. Rothschild's analysis is a good starting point, but he fails to give the complete picture. Without clear statements from governors it is difficult to be precise, but a broad analysis within which individual hospital experiences can be located requires a framework that looks at expenditure; rebuilding; the nature of different types of institutions; community resources; competition within the benevolent economy; the national economy, and the damaging effect of criticism.

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<sup>1</sup> *Hospital*, 29 October 1887, 73-74.

<sup>2</sup> *Charity Record & Philanthropic News*, 4 (1884), 362; *Charity*, November 1887, 151.

## 1. EVER INCREASING EXPENDITURE

Colonel Montefiore, the secretary of the COS's medical committee, informed the Select Committee on Metropolitan Hospitals in 1890 that expenditure was the main evil in hospital finance.<sup>3</sup> Expenditure could exert an enormous pressure on income, forcing the development of new sources of funding and a reliance on deficit financing. In 1855, the governors of the Royal Chest Hospital noted that they had been compelled to 'turn their attention to other modes of supply' because expenditure had exhausted the hospital's traditional sources of funding.<sup>4</sup> Few hospitals, however, were in the same position as University College Hospital. The governors managed to stumble from one debt crisis to the next and subscribers were constantly misled over the seriousness of the hospital's financial position. By 1897 a deficit of over £19,000 forced the governors to close nearly a quarter of the hospital's beds, which for the *BMJ* was 'convincing proof that the chronic financial difficulties of the hospitals in London [had] reached a serious crisis'.<sup>5</sup> Economies were attempted; champagne was removed as an item of medical expenditure, but the hospital's resources were insufficient to meet the annual expenditure.<sup>6</sup> As expenditure increased debts mounted and bills were left unpaid until additional money could be raised to pay them. The governors practised a policy of brinkmanship, paying only those creditors that pressed hardest. It should not be surprising with such a burden of debt that the governors energetically obtained new sources of funding and sold invested property to raise additional capital. A few benefactors, like George Moore in 1876, recognised that this would only reduce the hospital's future income and when they left money to the hospital they stipulated that it had to be invested.<sup>7</sup> However, given University College Hospital's financial position the governors felt that they had few alternatives and relied on fortuitous legacies to bail the hospital out of its financial difficulties.

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<sup>3</sup> SC of the House of Lords on Metropolitan Hospitals, 1st Report, *PP* 1890 XIX, 15.

<sup>4</sup> German Hospital 1855 Annual Report.

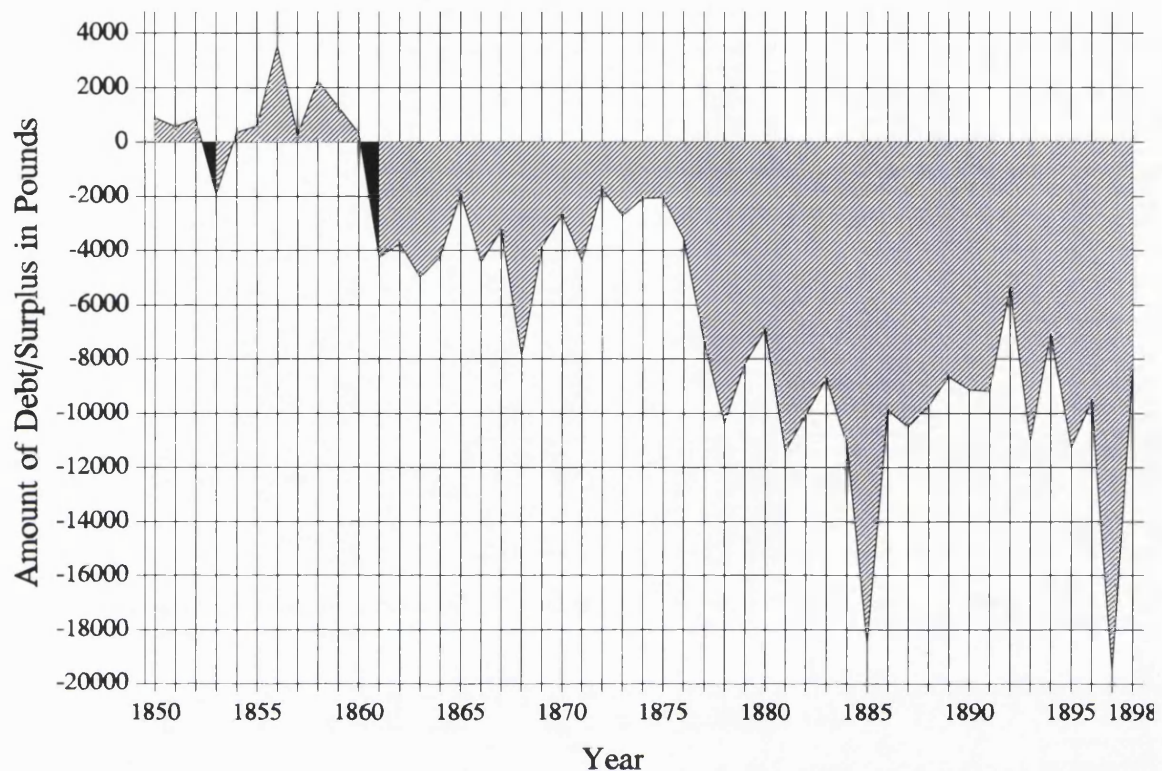
<sup>5</sup> *BMJ*, 2 (1897), 1805.

<sup>6</sup> UCH Archive, House & Finance Committee, A1/3/3.

<sup>7</sup> UCH Archive, General Committee, A1/2/4.



Figure 4.1: UCH - Income Against Expenditure



Note: Graph produced by subtracting the loans, debts, sale of property and investments from income to produce a comparison between recurrent expenditure and recurrent income. This method overcomes the problem found in hospital accounts where debts and liabilities were often hidden.

Source: Annual Reports, 1850-1898.

University College Hospital's position was extreme, but not unusual. The Middlesex shared its propensity for debt and the Norfolk and Norwich Hospital had to launch its first major appeal in 1801 as running costs were not covered by income.<sup>8</sup> It was a crisis that was repeated at other institutions throughout the century. Even the prosperous St.Bartholomew's had to sell £3,000 of its investments in 1854 to meet

<sup>8</sup> SC on Metropolitan Hospitals, 2nd Report, *PP* 1890/1 XIII, 123; S.Cherry, 'The Role of the Provincial Hospital: The Norfolk and Norwich Hospital 1771-1880', *Population Studies*, 26 (1972), 297.

expenditure.<sup>9</sup> Public appeals for donations were a more common approach to an expenditure crisis: the London launched its first public appeal in 1807 to ‘rescue it from serious embarrassment’ and followed it with a further appeal in 1814.<sup>10</sup> In 1878 the foundation of the hospital’s quinquennial appeal was an effort to meet mounting debts and represented a move away from the hospital’s traditional reliance on dividends and subscriptions. Appeals, however, were only a short-term solution and did nothing to reduce total expenditure. Governors found it harder to cut spending than raise money, though all institutions regularly made small economies. From the foundation of the voluntary hospitals in the eighteenth century, administrators had been anxious to anticipate any allegation of mismanagement and every increase in expenditure was defended to maintain public confidence.<sup>11</sup> In an attempt to justify large items of spending, expenditure was divided into ‘ordinary’ and ‘extraordinary’ spending in an effort to alleviate subscribers’ concerns. Under ‘extraordinary’ expenditure capital costs were placed to emphasize that the expenditure was unusual and irregular. This, however, could not hide the fact that expenditure increased dramatically. By 1890 the metropolitan hospitals were on average spending £2,000 per day and from 1891 to 1911 annual expenditure rose from approximately £643,000 to £1,360,000.<sup>12</sup> Not even the most prudent of administrators could prevent this dramatic increase.

Growth rates varied considerably between institutions, but a common trend can be seen when the expenditure at St.Bartholomew’s and the Hospital for Sick Children is compared.

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<sup>9</sup> SBH Archive, Governors’ Minutes, Ha/1/21.

<sup>10</sup> London Hospital 1850 Annual Report, 8.

<sup>11</sup> A.Borsay, “Persons of Honour and Reputation”: The Voluntary Hospital in the Age of Corruption’, *Medical History*, 35 (1991), 286-7.

<sup>12</sup> R.Pinker, *English Hospital Statistics 1861-1939* (1966), 162.

Table 4.1: Hospital for Sick Children's Expenditure.

	1860			1895			Increase %
	£	s	d	£	s	d	
Provisions	1068	14	8	2397	3	2	55.4
Medicine	217	13	2	1284	12	7	83.1
Wages	617	7	4	3016	10	9	79.5
Improvements	-	-	-	882	0	2	100.0
Management	-	-	-	490	16	6	100.0
<b>TOTAL</b>	<b>1903</b>	<b>15</b>	<b>2</b>	<b>8071</b>	<b>0</b>	<b>2</b>	<b>76.4</b>

Source: Annual Reports 1855 & 1895.

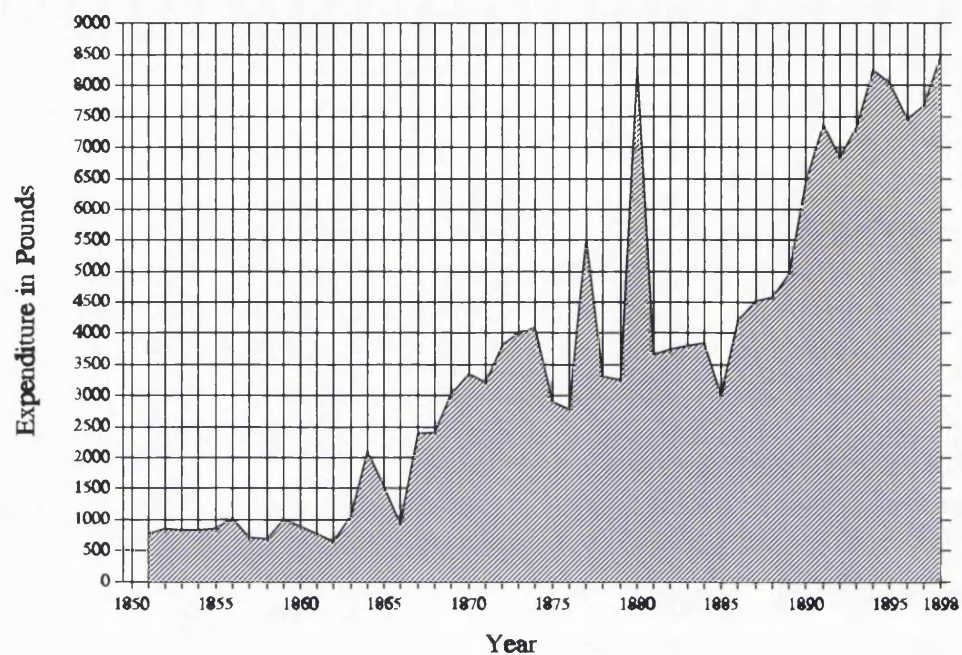
Table 4.2: St Bartholomew's Expenditure.

	1855			1895			Increase %
	£	s	d	£	s	d	
Provisions	2409	10	10	3610	16	6	33.3
Medicine	627	7	4	3275	19	9	80.9
Wages	1098	11	8	5558	9	5	80.2
Improvements	158	10	0	1094	8	0	85.6
Management	746	5	6	3512	10	10	78.8
<b>TOTAL</b>	<b>5040</b>	<b>5</b>	<b>8</b>	<b>17052</b>	<b>4</b>	<b>6</b>	<b>70.4</b>

Source: SBH Archive, General Account Books, Hb/23/3-4.

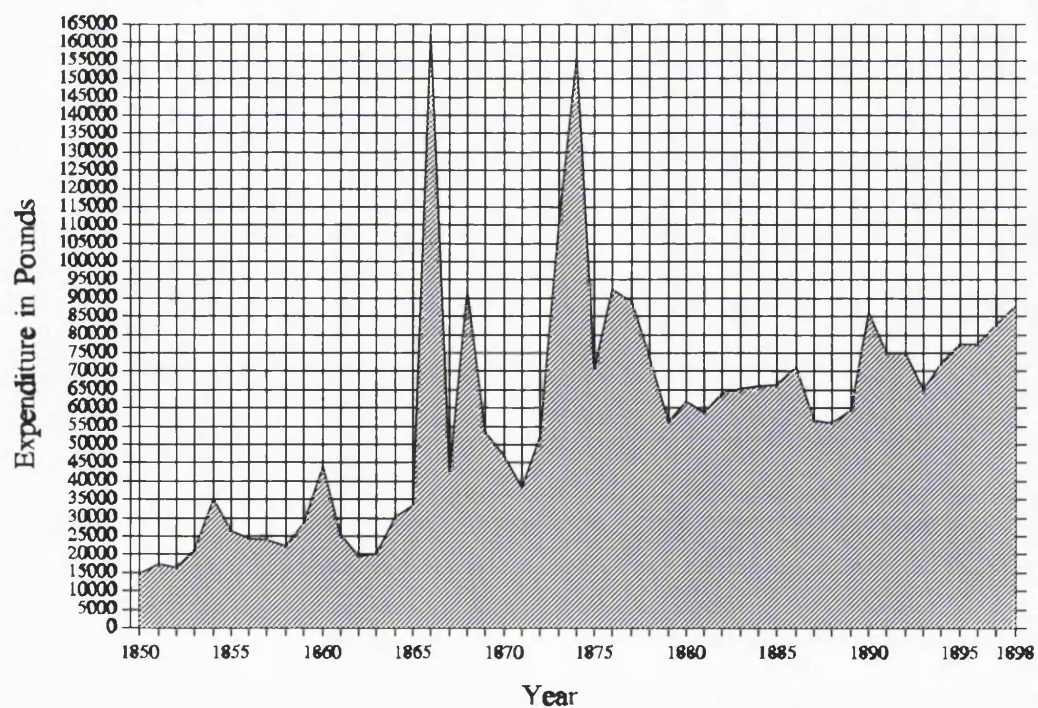
The general rise in spending can be illustrated by the experiences of the Royal Chest Hospital and the London, with 'spikes' in expenditure occurring during periods of rebuilding.

Figure 4.2: RCH Expenditure (1850-1898)



Source: Annual Reports, 1850-1898.

Figure 4.3: London Hospital: Expenditure (1850-1898)



Source: Annual Reports, 1850-1898.

Why did expenditure increase in this manner? The ‘excessive amounts spent by hospitals in advertising and collecting, printing stationery and postage’ were persistently attacked, but the reason for the universal rise in spending lay elsewhere.<sup>13</sup> Large extravagances were uncommon. When the governors of the German Hospital investigated expenditure in 1856, they found that it was an increase in ‘essential items’ that was raising costs.<sup>14</sup> George Goschen explained in 1887 that ‘the expenditure of an hospital was increased by new inventions in medical science, and that the very perfection at which medical science has arrived had increased the expenditure of hospitals’. Under these conditions ‘it cost more to cure a man than formerly’.<sup>15</sup> Changes in therapeutic practice with the development of new clinical aids, advances in surgical practice, and the growth of scientific medicine, all signified new procedures for medical practitioners.<sup>16</sup> The doctors’ junior position in hospital management, discussed in Chapter 6, ensured that they had no control over spending. Doctors therefore were forced to match their medical demands to the governors’ reluctance to spend large amounts on new clinical procedures; decisions that frequently acted as a brake on development. At the Royal Chest Hospital the governors opposed the purchase of a microscope on which the medical committee had

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<sup>13</sup> *Hansard* (H of L), Vol. 338, 29 July, col. 1552.

<sup>14</sup> GH Archive, Hospital Committee, A/2/3.

<sup>15</sup> *Charity Record & Philanthropic News*, 7 (1887), 147.

<sup>16</sup> For example see S.Reise, *Medicine and the Reign of Technology* (Cambridge, 1990) for the rise of clinical technology. For the growth of specialism and the change in therapeutic and surgical practice see R.Stevens, *Medical Practice in Modern England: The Impact of Specialization and State Medicine* (1966); R.Shryock, *The Development of Modern Medicine*, (1948); A.Youngson, *The Scientific Revolution in Victorian Medicine* (1979). C.Lawrence, "Incommunicable Knowledge", *Journal of Contemporary History*, 20 (1985) offers a more thought provoking analysis. Other studies, like L.Granshaw, ‘Knowledge of Bodies or Bodies of Knowledge? Surgeons, Anatomists and Rectal Surgery, 1830-1985’ in C.Lawrence (ed.), *Medical Theory, Surgical Practice* (1992) or A.Hardy, ‘Tracheotomy versus Intubation: Surgical Intervention in Diphtheria in Europe and the United States, 1825-1930’, *Bulletin of the History of Medicine*, 66 (1992), illustrate the development of particular practices. J.H.Warner, *The Therapeutic Perspective* (Cambridge, 1986) and M.J.Vogel & C.E.Rosenberg, *The Therapeutic Revolution* (Philadelphia, 1979) look at these developments from an American perspective, but offer an insight into the development of modern medicine and how changes were perceived and adopted.

insisted because they considered it unnecessarily expensive.<sup>17</sup> Resistance was not always encountered, but progress was slow as both governors and doctors had to overcome their innate conservatism. Changes, however, were made. Between 1855 and 1875 29 specialist departments were established in London's general hospitals and in all medical institutions new procedures were adopted.<sup>18</sup> Dr Philip Hensley, writing in the *Charity Record & Philanthropic News*, expressed a common view. He felt, as a physician at the Royal Chest Hospital, that he 'had never considered the question of expense in recommending what he thought was right for the patients of the hospital'.<sup>19</sup> Governors lacked the professional knowledge to argue effectively against these moves when their medical staff insisted that developments were a medical necessity. The effect was to drive up medical expenditure. At the London expenditure on drugs and chemicals rose from £3,315 7s 2d in 1889 to £4,995 11s 4d in 1897, a rise of 33.6% in nine years.<sup>20</sup> The Finance Committee was aware of this problem and appointed a special 'drugs' auditor to check the contracts and purchasing.<sup>21</sup> The rise was equally striking at the German Hospital, where from 1854 to 1898 medical expenditure rose by 333.1%.<sup>22</sup> Doctors demanded new drugs and new instruments and governors had to pay for them. In most London hospitals a compromise was reached and doctors modified their demands and attempted to control medical expenditure.

Developments in scientific medicine and therapeutic practices were not the only advancements in patient care that affected expenditure. Nursing costs also spiralled, assisted by the move to train nurses with the growth of nursing sisterhoods and the work of the Nightingale School at St.Thomas's.<sup>23</sup> Contemporaries like Sydney Waterlow

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<sup>17</sup> RCH Archive, Medical Committee, A3/1.

<sup>18</sup> M.J.Peterson, *The Medical Profession in Mid-Victorian London* (Berkeley, 1978), 248.

<sup>19</sup> *Charity Record & Philanthropic News*, 5 (1885), 197.

<sup>20</sup> London Hospital 1890 & 1898 Annual Reports.

<sup>21</sup> LH Archive, Finance Committee, A/9/51.

<sup>22</sup> German Hospital 1854 & 1895 Annual Reports.

<sup>23</sup> See B.Abel Smith, *A History of the Nursing Profession* (1960) or F.B.Smith, *Florence Nightingale: Reputation and Power* (1982). For the nursing sisterhoods see note 157,



believed that this was an important factor in increasing hospital expenditure.<sup>24</sup> Extensive programmes of nursing reform did not initially prove expensive and created a new source of income.<sup>25</sup> However, with the introduction of new nursing systems a new assertive class of matron emerged, demanding a higher ratio of nursing staff to patients and for improved facilities as nurses were no longer to be the Sarah Gamps of the first half of the nineteenth century. To house the probationers, additional accommodation and training schools had to be built and extra domestic staff employed to look after them. At King's College Hospital the governors were reluctant to pay for improvements, and so alienated the sisterhood employed to train their nurses.<sup>26</sup> The transition to a new system of nursing was not always smooth, as the nursing dispute at Guy's outlined in Chapter 6 shows; however, reform was increasingly seen as essential if the hospital wanted to provide the most advanced medical care available. Nursing reform consequently contained an inherent trend that favoured an increase in wages and a rise in expenditure.

An increase in medical and nursing costs is only part of the explanation. Contemporaries identified a further reason. The Duke of Cambridge, at a meeting in 1888 at Mansion House in aid of the London, explained that the growth in patient numbers increased expenditure.<sup>27</sup> The rise could be dramatic. Admissions statistics are notoriously inaccurate. Governors needed '... to make a goodly show of work in the eyes of the public, with the object... of attracting subscribers' and admissions became a useful tool in their claim for support.<sup>28</sup> However, the figure 4.4 illustrates the general rise in patient numbers.

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### Chapter 3.

<sup>24</sup> *Hospital*, 17 November 1888, 101.

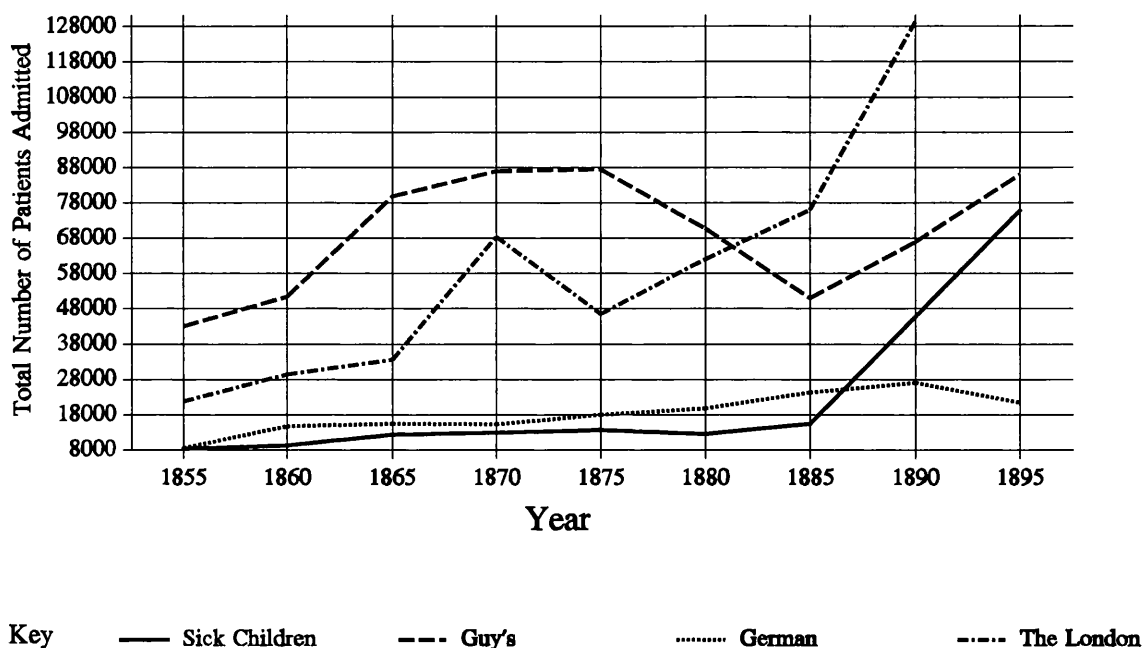
<sup>25</sup> See pages 128-30.

<sup>26</sup> C.Helmstadter, 'Robert Bentley Todd, St.John's House and the Origins of the Modern Trained Nurse' *Bulletin of the History of Medicine*, 67 (1993), 313.

<sup>27</sup> LH Archive, Scrapbook, A26/31

<sup>28</sup> M.Mackenzie, 'The Use and Abuse of Hospitals', *Contemporary Review*, 58 (1890), 507.

Figure 4.4: Patient Admissions (1850-1895)



NOTE: Admissions at Guy's fell dramatically from 1875 to 1885 because of the introduction of patient payments, while at the London the criteria for determining admissions changed in 1875 as renewal tickets were no longer counted.

Source: Annual Reports 1855-1895; Guy's Archive, Superintendent Reports, A67/2-8.

This was experienced across all hospital types and even at St.Bartholomew's, which had no need to attract direct philanthropy, admissions doubled between 1861 and 1881.<sup>29</sup> Expansion can be explained by developments in medicine and nursing that served to alter the public's harsh perception of the hospital. Hospitals built on their new popularity, though the result was a rapid increase in admissions as hospitals became a viable location for medical care. Doctors fuelled this increase by their desire for a greater pool of interesting cases and clinical material, while the growth of the Sunday Fund and the Saturday Fund raised the hospitals' profile and gave the impression that contribution implied a right to treatment.<sup>30</sup> In many cases, such as at the London and at St.Thomas's,

<sup>29</sup> SBH Archive, Medical Committee, Mc/1/2.

<sup>30</sup> J.Brand, *Doctors and the State* (Baltimore, 1965), 193.



patients had to be turned away. Hospitals rested precariously between their new 'popularity', their need for more patients, and the constraints of finance.

The link between an increase in patient numbers and rising expenditure is not hard to make. Governors struggled to cut spending, but they could not reduce admissions without damaging their image and public support. More patients demanded more services. The increase in expenditure that resulted is reflected in the rise in the amount needed to treat a patient. Between 1864 and 1891 the average weekly cost of inpatient care in London rose by 203.3%.<sup>31</sup> Metropolitan hospitals were always more expensive than their provincial counterparts, but a similar increase in spending occurred outside London. All expenditure connected to the running of the hospital increased, as a growing number of patients had to be cared for, housed, and fed.

Institutional costs were the hospitals' main expense, but the link between spending and the patient admissions is seen in the amounts governors increasingly had to spend on food, especially as from 1873 the agricultural depression saw a marked fall in food prices. Food was the largest component in expenditure, representing a quarter of the London hospitals' running costs in 1896.<sup>32</sup> Provisions were not bought on the open market as they could not be stored in the quantities required, so governors negotiated contracts with suppliers. Fluctuations in price were not accounted for and the system often resulted in poor quality food as contractors bought the cheapest goods available to remain within their costing. According to the *Hospital*, which ran a series of articles in 1896 and 1897 on expenditure, patients could be fed on a minimum of 4s. per week.<sup>33</sup> Governors were not inclined to be extravagant, even with the medical staff prescribing specialist diets, but as the number of admissions rose so to did the amount of food required. At the German Hospital the number of inpatients admitted increased by 164.3% between 1854 and 1895 and the cost of provisions by 240.2%.<sup>34</sup> When the hospital's governors criticised the medical staff for their increased purchasing of beers and spirits, the doctors in their

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<sup>31</sup> F.Buckle, *Vital and Economical Statistics of Hospitals and Infirmaries Etc* (1865); SC on Metropolitan Hospitals, 2nd Report, 799-802.

<sup>32</sup> *Hospital*, 25 April 1896, 61.

<sup>33</sup> *Hospital*, 28 March 1896, 436.

<sup>34</sup> German Hospital 1854 & 1895 Annual Reports.

defence cited an increase in admissions as the main reason for the rise in expenditure.<sup>35</sup> Other London hospitals experienced a similar rise that defied their efforts to economise.

It was an inescapable consequence of development that as hospitals came to treat more patients and expand their medical remit, so their expenditure also rose. To care for the sick increasingly meant new wards, more doctors, more specialism and better provision. Under these conditions traditional sources of funding, especially charitable resources, came under increasing pressure. The solution was either to close wards and restrict treatment, a move that aroused opposition when attempted and went against the hospitals' medical and philanthropic character, or develop additional sources of funding. The result was a more diverse financial strategy, often not by intention but by necessity.

## 2. BUILDING MANIA

One factor that promoted an increase in expenditure needs to be considered separately. Henry Burdett, at a meeting of the BMA in 1881, felt that a building mania had enthralled London's hospitals. For him the result was a physical expansion of provision and a dramatic rise in expenditure, while new wards remained empty.<sup>36</sup> A rise in admissions and the altered criteria of medical care arising from developments in medicine made new buildings essential. The publicity surrounding the pavilion plan after Florence Nightingale's campaigns and her constant references to the new design in her *Notes on Hospitals*, added an extra dimension to governors' enthusiasm to rebuild, motivating them to construct new edifices in the interests of a 'well-tempered' and sanitary environment.<sup>37</sup> St.Mark's Hospital for Fistula rebuilt on these sanitary grounds in 1895, having unsuccessfully attempted to make improvements to the old building. The new hospital,

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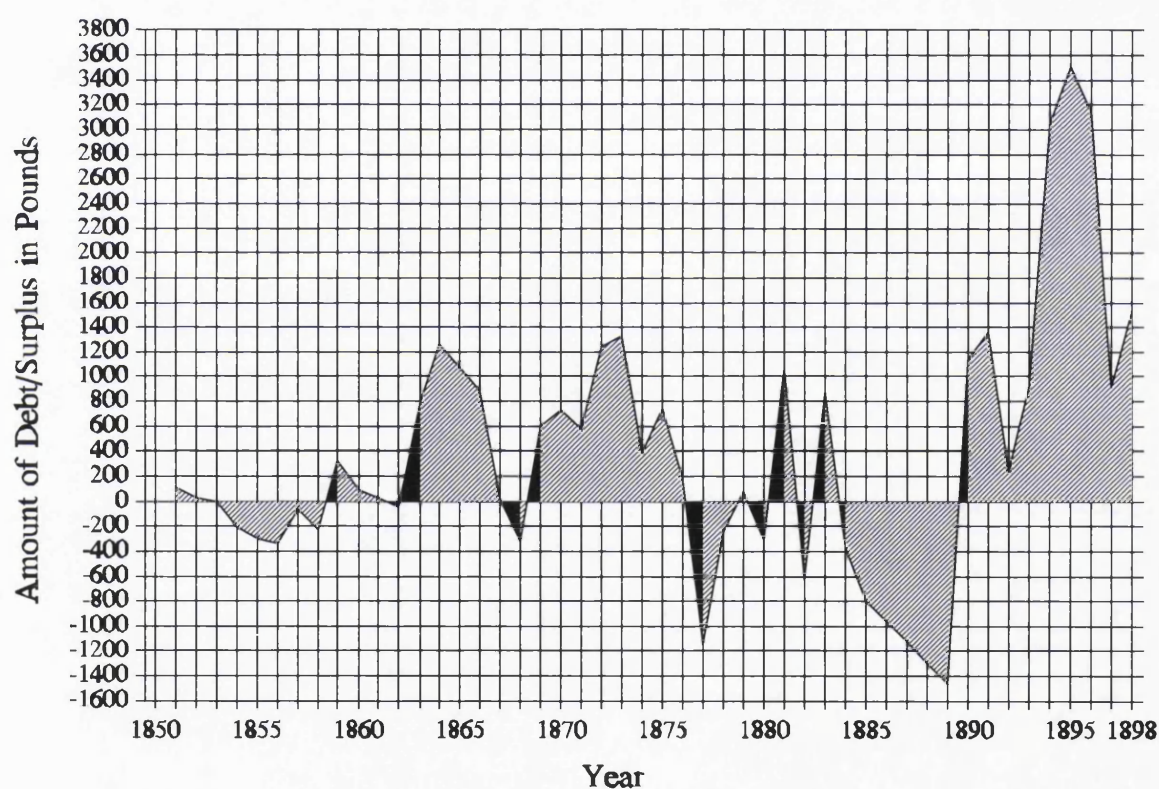
<sup>35</sup> GH Archive, Board of Hospital Management, A/8/4.

<sup>36</sup> *BMJ*, 2 (1881), 646.

<sup>37</sup> F.Nightingale, *Notes on Hospitals* (1863); R.Banham, *Architecture of a Well-Tempered Environment* (1969) also see J.R.B.Taylor, *Hospital and Asylum Architecture in England 1840-1914: Buildings for Health Care* (1991). Not all areas were motivated by these concerns. In Manchester the Royal Infirmary was rebuilt as part of the civic improvement of the Piccadilly district where it was located: J.V.Pickstone, *Medicine and Industrial Society* (Manchester, 1985), 100.

to cope with the number admissions, was twice the size of the old one, but debt forced the governors to sell investments and wards remained empty, vindicating Burdett's earlier assessment.<sup>38</sup> Even ignoring financial problems, the result was not always successful. Despite rebuilding, the governors of the Hospital for Sick Children still had to close the hospital periodically because of outbreaks of disease. According to Abel Smith 'the new spacious hospitals were expensive to build and expensive to run'; a view borne out by the testimony of contemporaries and the financial experiences of London's medical institutions.<sup>39</sup>

Figure 4.5: Royal Chest Hospital - Income Against Expenditure.



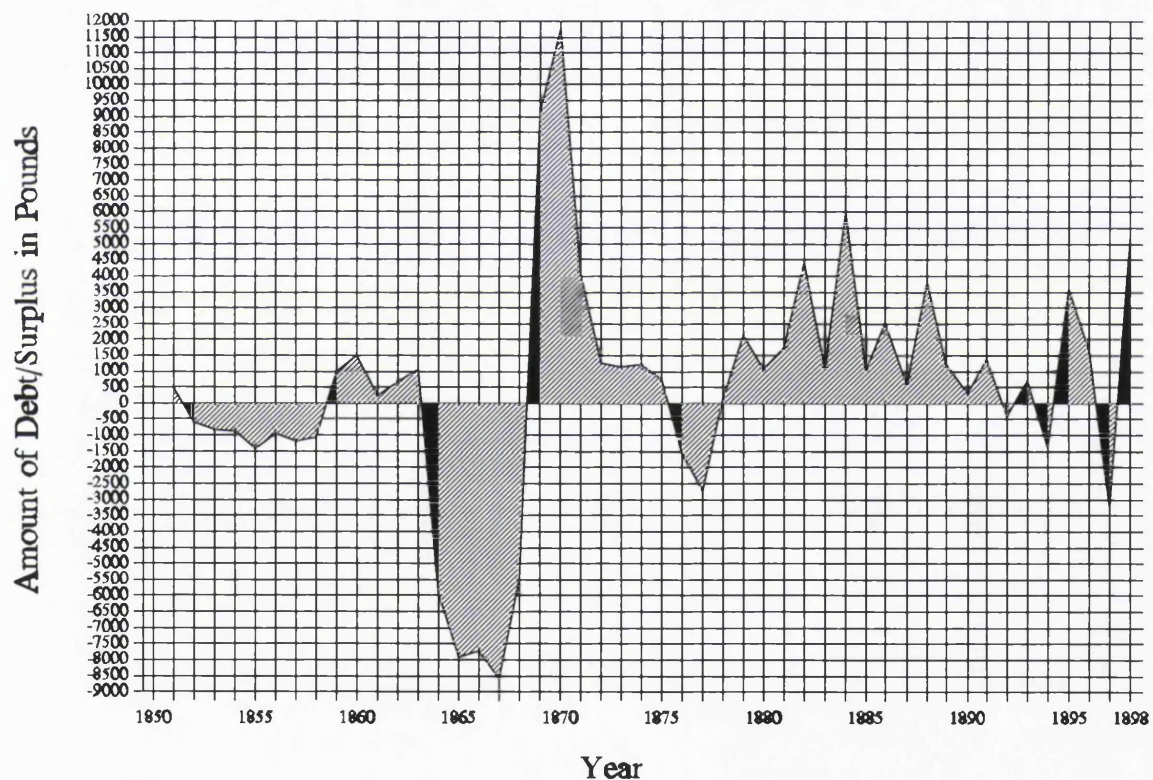
Source: Annual Reports, 1850-1898.

<sup>38</sup> L.Granshaw, *St Mark's Hospital, London: A Social History of a Specialist Hospital* (1985), 75-76.

<sup>39</sup> B.Abel Smith, *The Hospitals 1800-1948* (1964), 154.

Building exerted a considerable pressure on hospital finance. New buildings raised running costs and increased overall expenditure, but the main pressure was felt during building. Debt peaked in the years when new wards or clinical facilities were built, as shown by the experiences of the German Hospital and the Royal Chest Hospital. Loans were invariably sought to meet building costs until enough income could be raised from philanthropy to meet the accumulated debt. This policy was adopted by the Royal Chest Hospital. In 1889, the governors sold £6,000 in consols 'for the purpose of paying sundry debts incurred in the building of the new wing of the Hospital'.<sup>40</sup>

Figure 4.6: German Hospital- Income Against Expenditure.



Source: Annual Reports, 1855-1898.

<sup>40</sup> *Charity Record & Philanthropic News*, 9 (1889), 292.

At the German Hospital a different solution was found when rebuilding left the hospital financially embarrassed. At first legacies and investments were liquidated, followed by a series of loans and in 1867 a bazaar was organised. 1867 marked a turning point and successful appeals to charity enabled the governors to build up the hospital's surplus income and investments.<sup>41</sup> The governors had apparently learnt their lesson. For the rest of the nineteenth century they tried not to over extend the hospital's finances and built up investments to provide a reliable income that partially freed them from the vagaries of direct philanthropy.

Few administrators were as prudent as the governors of the Hospital for Sick Children who attempted to save their annual profits until they could afford to build. However, this was not always possible, especially when initial estimates were exceeded. Occasionally the governors were forced to borrow to cover their expansion and when they ambitiously bought St.John's & Elizabeth Hospital in 1898, they had to borrow £4,000.<sup>42</sup> Most hospitals, however, built when there was a need rather than the funds or when building costs were low, a phenomenon that counters Whitehand's view of an institutional building cycle.<sup>43</sup> At University College Hospital and the London expenditure peaked during years of rebuilding (see figures 4.1 and 4.3). It was not, however, until 1888 that the chairman of the London's House Committee, acknowledged this pressure on the hospital's finances. He noted that 'the very large expenditure' had been incurred with the rebuilding of the medical college and that this had placed a strain on the hospital's income.<sup>44</sup> Similar problems were encountered at all hospitals and resources were modified accordingly. The Brompton faced financial problems after opening a new building in 1882, and the Swansea General & Eye Hospital experienced building related financial

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<sup>41</sup> GH Archive, Hospital Committee, A/2/4.

<sup>42</sup> GOS Archive, Finance Committee, GOS/1/8/2.

<sup>43</sup> See J.Whitehand, 'Building Cycles and the Spatial Pattern of Urban Growth', *Transactions of the British Institute of Geographers*, 56 (1972).

<sup>44</sup> LH Archive, Scrapbook, A/26/31.

difficulties after 1876.<sup>45</sup> At the Swansea General, the governors were forced to court working-class organisations to raise income and they opened a provident dispensary in 1877 to relieve the hospital's strained resources, a move that proved highly profitable.<sup>46</sup> St.Thomas's equally had to adopt a new financial strategy after 'the folly of overbuilding'. Its move to Lambeth left it financially embarrassed with only 13 of the 21 wards open.<sup>47</sup> When combined with a fall in income from the hospital's endowments, pressure was exerted in the face of considerable opposition to admit paying patients.<sup>48</sup>

The most common response to the financial strain of building was the sale of invested property. All hospitals were forced to do this at one point or another. In 1879 the governors of St.Bartholomew's sold £6,000 in consols to pay for a new chemical theatre. The decision was made because they were aware that the 'ordinary' income for that year was insufficient to pay for the building work.<sup>49</sup> At St.Bartholomew's, the move was greeted with no anxiety and was seen as a temporary measure. At other hospitals, the sale of invested property was frequently used to cover the debts generated by building. Where traditional sources of finance could not pay for expansion new sources of income had to be found, so altering the hospitals' financial make-up and encouraging diversification to avoid debt.

### 3. NATURE OF THE HOSPITAL

Hospitals, as explained in Chapter 1, can be divided into broad categories and though this categorisation is generalised, it allows an identification of the characteristic restraints and pressures on income facing each different type of hospital. The financial experiences of

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<sup>45</sup> P.Bishop et. al., *The Seven Ages of the Brompton* (Guildford, 1991), 68.; T.G.Davies, *Deeds not Words: A History of the Swansea General & Eye Hospital 1817-1948* (Cardiff, 1988), 75.

<sup>46</sup> Davies, *Deeds not Words*, 75-77.

<sup>47</sup> H.C.Burdett, *Hospitals and the State* (1881), 11.

<sup>48</sup> L.Granshaw, 'St.Thomas's Hospital, London 1850-1900' (Unpublished PhD Thesis, Bryn Mawr College, 1981), 390-421.

<sup>49</sup> SBH Archive, Governors' Minutes, Ha/1/24.

individual hospitals were influenced by the nature of the institution. This could either be a benefit, as in the specialist hospitals, assisting governors in their fundraising; or it could be a disadvantage, as in the teaching institutions, by placing an additional burden on expenditure.

Teaching hospitals became a feature of the Victorian medical environment as medical education moved out of the small, ill-equipped schools that had been established in the late-eighteenth century. It was widely acknowledged that ‘hospitals associated with medical schools’ were ‘somewhat more expensive than others’.<sup>50</sup> Teaching hospitals admitted more patients to provide their students with interesting clinical material and provided a wider variety of treatment techniques than other hospitals to fulfil their educational function. Only by continual improvement could these institutions maintain their competitive edge in their efforts to attract students. A higher level of expenditure and a greater pressure on resources was the consequence.

University College Hospital epitomises the pressures experienced by teaching hospitals. Founded in 1834 to provide clinical experience for medical undergraduates, the hospital constantly experienced a considerable pressure on its resources, driving it into debt. Contemporaries felt that University College Hospital had had a profound influence on medical education, but its educational function produced a continual pressure for expansion. The governors attempted to keep pace with developments in medical science, imposing demands on the hospital’s finances that the normal careful management of resources was ill-equipped to meet. For example an ‘electrical room’ for galvanic treatment was provided in 1867 to allow the medical staff to teach the diagnostic and curative uses of electricity. The room and the equipment cost £50.<sup>51</sup> From 1869 and 1880 drug expenditure alone rose by 146.7% and from 1876 to 1881 £1,922 was spent on surgical equipment.<sup>52</sup> The result of these demands was a permanent financial crisis.

To a certain extent all general hospitals experienced these pressures as they modified their charitable credentials to provide teaching facilities. The London had always benefited from its medical school, even though from 1853 it was managed and

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<sup>50</sup> *Hospital*, 5 January 1889, 214.

<sup>51</sup> UCH Archive, UNOF/2/3 (1).

<sup>52</sup> UCH Archive, UNOF/2/3 (2).



financed independently by the hospital's medical staff. Medical students provided key services during their training that the hospital did not have to pay for, but from the 1870s onwards the governors were increasingly aware that the college was facing a pressing financial crisis. To protect the hospital's reputation, the governors in 1876 agreed to give the college financial assistance.<sup>53</sup> Initially the agreement covered a set grant of £2,000 that was awarded annually for three years. However, when this temporary agreement was renewed in 1879, the governors and medical staff, after prolonged negotiation, agreed to assume joint responsibility for the college's finances.<sup>54</sup> The governors, in adopting an additional strain on the hospital's already insufficient resources, acquired a leading managerial role in the college on the invitation of the medical staff. Where the governors had previously had no control over the allocation of the college's resources, they were now able to direct them to the hospital's benefit.<sup>55</sup> However, it is doubtful if this was ever sufficient to match the college's financial demands. The doctors continued to draw a salary from the medical students' fees, but now any shortfall in the college's expenses was met from the annual grant. The hospital also subsidised the college's rebuilding. In 1885 the governors lent the college £15,000 at 3% interest and in doing so had to borrow £4,000 and sell £5,000 of its annuities to lend the money.<sup>56</sup> Unlike University College Hospital, the London's move to fund the medical college did not directly promote financial diversification, but it exerted additional financial pressure that made diversification desirable.

The situation was different at specialist hospitals. Specialist hospitals did not experience the same financial problems as their general counterparts, partly because of their nature. Though specialist hospitals were widely attacked, subscribers gave to specialist hospitals because they evoked sympathy or, in the case of subscriptions from businesses, because they held a material benefit and provided a cheap alternative to

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<sup>53</sup> LH Archive, House Committee, A/5/37; Medical Committee, Mc/A/1/3.

<sup>54</sup> LH Archive, Medical Committee, Mc/A/1/3.

<sup>55</sup> Other institutions lacked this sharp contrast between the medical college and the hospital, allowing the governors more control over the allocation of resources through a control of financial resources.

<sup>56</sup> LH Archive, House Committee, A/5/42.



insurance.<sup>57</sup> The Royal Chest Hospital attracted particular support from the printing and textile firms where chest diseases were common.<sup>58</sup> This natural advantage in attracting charity, when merged with their energetic fundraising tactics, ensured that specialist hospitals could increase their charitable support by playing on their nature. At specialist hospitals voluntary contributions did not fall in the same proportion to the other sources of income as at the general hospitals, and due to this there was less pressure to pursue new sources of funding.

The Hospital for Sick Children openly manipulated its nature to provoke sympathy. The hospital was particularly fortunate as contemporaries hastened ‘to extend the hand of mercy...’ to sick children.<sup>59</sup> The *Hospital* felt that the Hospital for Sick Children was perhaps ‘the most popular of all hospitals in the eyes of the public’ and the *Illustrated Times* noted that few people could resist the sympathy it inspired.<sup>60</sup> The governors played on the institution’s nature, issuing a regular stream of pamphlets. On these emotional grounds many gave money. However, not even the Hospital for Sick Children could rely on sympathy and emotion alone. In 1893 Adrian Hope complained about the ‘serious decrease in subscriptions and donations’ and the governors were forced to sell some of the hospital’s assets to forestall a deficit.<sup>61</sup> However, the hospital’s nature did generate a sufficient flow of charitable resources to ensure that the need to develop a diverse financial base was less acute.

Where specialist hospitals could play positively on their nature to attract charitable funding, endowed hospitals did not have to make public appeals. Guy’s and St.Thomas’s did solicit philanthropy from the 1880s onwards as the agricultural depression had eroded the mainstay of their financial support, but until the late 1870s all endowed hospitals were largely reliant on their endowed income. Income from charitable sources was often marginal. Periodic financial problems were encountered that encouraged the governors

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<sup>57</sup> See pages 56-7.

<sup>58</sup> A.S.Wohl, *Endangered Lives: Public Health in Victorian Britain* (1984), 260; 277.

<sup>59</sup> *Hospital*, 19 March 1887, 420.

<sup>60</sup> *Hospital*, 5 August 1893, 290; *Illustrated Times*, 24 April 1858, 302.

<sup>61</sup> GOS Archive, Press Cuttings, GOS/8/153.

at endowed hospitals to adopt alternative sources of funding. Endowed hospitals did diversify their finances, but until the late 1870s this was a less anxious development and often a response to opportunity rather than need. After 1876, Guy's and St. Thomas's, with their traditional sources of funding greatly reduced, pursued a policy of crisis management that saw them adopting innovative and widely criticised sources of funding (see below). The general opinion, however, was that these were well financed. It should not therefore be surprising that many hospitals sought to mimic them and invest surplus income to build up a pseudo-endowed status to reduced their dependence on unreliable sources of funding.

The hospitals' nature played an important role in influencing the financial strategies adopted by individual hospitals. The income available to an individual hospital was not entirely dependent on its type, but the hospitals' nature was an important factor in contributing to the pace of financial diversification. At the teaching hospitals there was a pressing need to develop new sources of funding; at the endowed hospitals, this need was not present until the late 1870s.

#### 4. COMMUNITY RESOURCES

It was to the local community that governors first directed their appeals and new institutions initially drew most of their support from the districts surrounding them. At the Royal Chest Hospital in the 1850s the majority of subscribers came from the City Road area where the hospital was situated, and only gradually was its appeal extended beyond these neighbourhoods. Burdett exalted the benefits of local collection schemes in 1877 because they established exclusive areas of support and limited competition.<sup>62</sup> Where this might work in the provinces, it was inappropriate for the capital. The *Lancet* felt that 'it is noteworthy that the London Hospitals are badly off mainly because they are in London'.<sup>63</sup> Provincial hospitals could become the centre of civic pride, but in London the number of charitable institutions ensured that the hospital had to compete for voluntary contributions. Levels of local identification with hospitals varied, but no

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<sup>62</sup> *BMJ*, 1 (1877), 405.

<sup>63</sup> *Lancet*, 2 (1898), 1647.

locality 'even if it were very rich' could sustain a hospital, though some were better suited than others.<sup>64</sup> Charity came from a small, often wealthy constituency in the community and where this was wanting hospitals faced considerable problems in motivating local benevolence. Population movements not only deprived hospitals of their original patient clientele, as at St.Bartholomew's, but also distanced them from their traditional networks of local support. The high degree of localism noted in Chapter 1 could fragment the benevolent economy and what made matters worse was that some areas had a habit of parsimony. The North London Hospital was continually under financial pressure as it was 'impossible to charm any money out of the tight-buttoned pockets of the people of North London'.<sup>65</sup> Though this was an exaggeration, it serves to show that community resources were important in determining the supply of direct philanthropy and the hospitals' financial experiences.

The London's position clearly shows these problems. Located in 'districts, where the density of the population renders the poor liable to disease of all kinds, and the nature of their employment exposes them constantly to the dangers of serious accident', it was the only 'general Hospital for the whole of the East End'.<sup>66</sup> Few wealthy or middle-class subscribers lived in the East End, certainly not enough to fund London's largest hospital. In 1890 the governors complained that 'the former inhabitants of East London, who contributed largely to this great institution, have moved to the suburbs'.<sup>67</sup> It was a widespread problem. As the middle classes moved to the suburbs and northern heights, arousing fears of social dislocation, local support for the hospitals in central London dwindled.<sup>68</sup> The London received donations and subscriptions from the local population, mainly through its People's Collection Fund, but the charitable resources available within the community were insufficient to meet its needs. The removal of the London's

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<sup>64</sup> LH Archive, Scrapbook, A/26/31.

<sup>65</sup> *Hospital*, 6 November 1886, 95.

<sup>66</sup> LH Archive, Scrapbook, A/26/31.

<sup>67</sup> LH Archive, Scrapbook, A/26/31.

<sup>68</sup> *Hospital*, 15 December 1888, 175; R.Dennis, *English Industrial Cities of the Nineteenth Century: A Social Geography* (Cambridge, 1984), 52-56.

community resources had been apparent from the mid-nineteenth century, and this had helped influence the governors to develop other sources of funding.

The London's position was not unique. Speakers at University College Hospital's jubilee dinner in 1884 complained that many of the hospital's wealthy subscribers had moved away from Russell Square and this had reduced the 'quantity' of its local support.<sup>69</sup> The absence of wealthy subscribers heightened the pressures exerted by the overcrowded nature of the medical market in central London. The charitable resources available within the community were strained by the sheer number of institutions in any one area. A map prepared by Frederick Mouat in 1883, a self-proclaimed expert on hospital management, pointed to a high concentration of hospitals in the West End and the *BMJ* asked the charitable public to think hard before they established another hospital there.<sup>70</sup> By 1887 the *Hospital* could complain that 'hospitals have sprung up without any definite regard to the requirements of the population or growth of individual communities, with the result that there is a tendency for the work of each institution to be overlapped by that of its neighbour'.<sup>71</sup> The area within two miles of Charing Cross was particularly overcrowded in institutional terms. University College Hospital had two general hospitals located within a mile and the Middlesex was only six minutes away. All theoretically drew on the same community resources. Contemporaries were increasingly anxious about the distribution of the capital's hospitals and the *BMJ* ascribed all the hospitals' problems to their poor distribution.<sup>72</sup> There was some discussion in 1894 of the possibility of relocating certain hospitals outside London to relieve the medical congestion of the West End, but the scheme was opposed as it was feared that patients would be attracted away from the teaching hospitals.<sup>73</sup>

Hospitals jealously guarded their community resources and new hospitals initially found it hard to compete. Both the Sunday Fund and the Prince of Wales Hospital Fund

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<sup>69</sup> *Charity Record & Philanthropic News*, 4 (1884), 188.

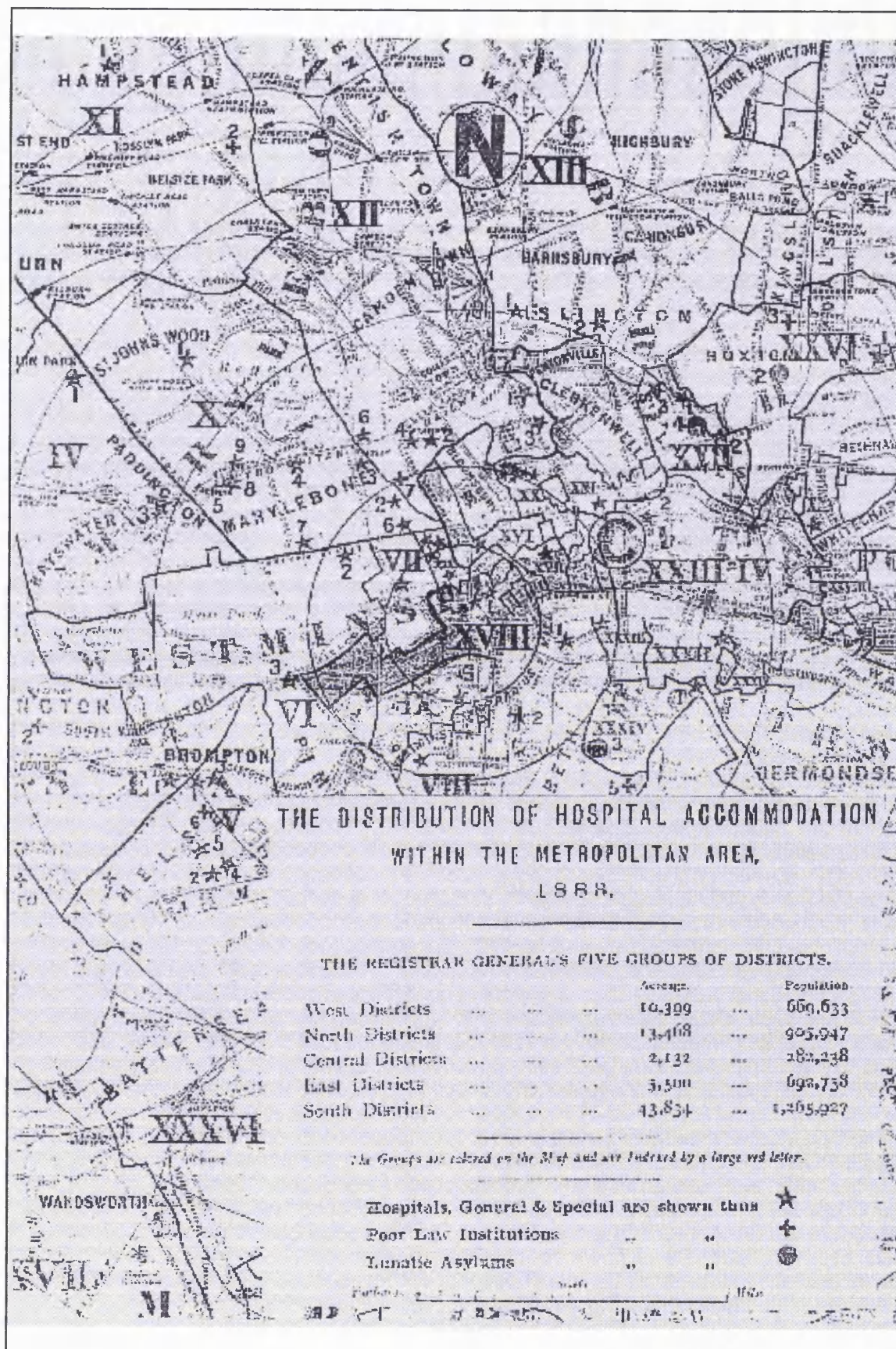
<sup>70</sup> *BMJ*, 2 (1878), 35.

<sup>71</sup> *Hospital*, 19 February 1887, 343.

<sup>72</sup> *BMJ*, 1 (1883), 776.

<sup>73</sup> *Hospital*, 3 February 1894, 314.





Source: F.Mouat & H.S.Snell, *Hospital Contruction and Management* (1883), Appendix.

were attacked because governors feared that they would threaten local collections and subscriptions.<sup>74</sup> This view was gradually modified as both funds' contributions became a valued feature of hospital finance. Hospitals equally resisted more localised schemes, especially the establishment of other institutions in their locality. The German Hospital and the North Western London Hospital advised the Duke of Westminster that his support for a new hospital in the area would be unwise as there was no clear need.<sup>75</sup> A similar move to found a hospital in Camberwell was resisted because 200 beds were empty at Guy's and St.Thomas's.<sup>76</sup> These were not altruistic attempts to save subscribers' money, but efforts to protect the financial base of the four hospitals concerned. Burdett recognised this problem and made the unprecedented suggestion of calling for legislation to regulate the foundation of hospitals.<sup>77</sup> Increasingly, hospital reformers were turning their attention to the problems of location and the possibility of state regulation was discussed in a climate where voluntarism seemed unable to provide the necessary coordination. Debate did not result in any positive action and by the start of the twentieth century no further progress had been made. The idea of the state intervening to influence the distribution of medical care in London was inspired by the chaotic nature of the medical market rather than by financial concerns. However, poor distribution in economic terms emphasised the difficulties many hospitals faced in collecting local charitable resources. To compensate, governors extended their appeals beyond their immediate locality to the metropolis and were forced to supplement the charitable resources available within the community with different sources of income.

## 5. COMPETITION WITHIN THE BENEVOLENT ECONOMY

The availability of charitable resources extended beyond the local community to London as a whole. The metropolitan benevolent economy was shaped by London's economy and

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<sup>74</sup> *Morning Post*, 2 September 1897, 2.

<sup>75</sup> GH Archive, Hospital Committee, A/2/7.

<sup>76</sup> *Times*, 24 June 1895, 11.

<sup>77</sup> *Hospital*, 15 March 1890, 370.

society and represented a highly sophisticated market. The *Hospital* compared it to a divided and leaderless state and within this 'chaos of benevolence' hospitals had to compete with other voluntary associations.<sup>78</sup> Charity was 'distinguished for its fitfulness and its impulse', and as a writer in *Truth* explained in 1883, it needed only a touching story of disaster to open its purse strings.<sup>79</sup> 'Foreign ventures' were a particular drain on the emotions and money of metropolitan subscribers.<sup>80</sup> The governors of the Royal Chest Hospital blamed the fall in charitable income in 1858 on the seductive nature of foreign causes, especially 'foreign objects in India'.<sup>81</sup> Governors and journals constantly lamented that charity had been directed away from 'kith and kin' to help the foreigner and convert the heathen while hospital beds remained closed. Appeals did not have to be directed overseas to have an effect. The *Manchester Guardian* commented in 1891 that 'when "General" Booth got his £100,000, careful observers predicted that it would be mainly drawn from the subscription list of other charities' and 'what is true of this fund is true of all other new charitable undertakings'.<sup>82</sup> Hospitals in comparison launched regular appeals and contributors were easily distracted by other, more immediate problems that were sensationalised by special appeals and newspaper funds. Even the governors of Hospital for Sick Children, normally highly successful in motivating charity, complained in 1890 about the difficulty in attracting funds in such a competitive environment.<sup>83</sup> The *Charity Record & Philanthropic News* saw this as a crucial problem for hospital finance and Lord Derby warned subscribers to 'help the novelty if you will and think it right, but do not help it at the cost of the old and well-tried institutions'.<sup>84</sup>

Competition was not limited to the different objects of charity. 'There was a keen and continuous competition between hospitals' and the total number of medical charities

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<sup>78</sup> *Hospital*, 22 September 1888, 397.

<sup>79</sup> *Truth*, 19 April 1883, 539.

<sup>80</sup> *Hospital*, 14 November 1891, 74.

<sup>81</sup> RCH 1858 Annual Report.

<sup>82</sup> Cited in LH Archive, Press Cuttings, A/26/8.

<sup>83</sup> SC on Metropolitan Hospitals, 2nd Report, 472.

<sup>84</sup> *Charity Record & Philanthropic News*, 2 (1881), 72; *Hospital*, 10 January 1891, 228.

in London was 'larger than the public can be induced to support'.<sup>85</sup> When Guy's announced its first public appeal in 1886, the *BMJ* hoped that it would not divert benevolence away from those institutions that depended on charity.<sup>86</sup> The view was too optimistic. One hospital's appeal was often another's hardship and the *Hospital* asked administrators who had had a successful appeal to refrain from capitalising on their success and let the less fortunate 'scramble for bread'.<sup>87</sup> When appeals occurred simultaneously, the result was to reduce their general effectiveness. The chairman of the London complained that the hospital's 1888 appeal had not been as 'entirely satisfactory as they had expected - due, of course, to the increased number of hospitals that were compelled to appeal for funds'.<sup>88</sup>

Particular acrimony was directed at the specialist hospitals. Dainton has described the nineteenth century as an 'age of specialisation', but contemporaries were rarely as enthusiastic.<sup>89</sup> Specialist hospitals were rounded on as 'a nuisance to the public' and the medical profession regarded specialists as little more than quacks and saw their hospitals as damaging to general practice.<sup>90</sup> Doctors' professional self-interests merged with governors' anxieties, though the public were less antagonistic and offered their support to these new institutions. By the 1870s the pace at which specialist hospitals were being founded had slowed and initial antagonism was gradually modified as many specialist hospitals had become leading institutions and general hospitals had started to establish their own specialist wards. However, throughout much of the period they were castigated as overstocking and overcrowding the existing medical market. Contemporaries felt that the specialist hospitals' aggressive fundraising deflected charity to unnecessary causes. According to Sir Andrew Clark, President of the Royal College of Physicians, these institutions 'divert the funds in a direction in which they ought not to be employed, and

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<sup>85</sup> SC on Metropolitan Hospitals, 1st Report, 16; *Lancet*, 1 (1858), 48.

<sup>86</sup> *BMJ*, 2 (1886), 1230.

<sup>87</sup> *Hospital*, 14 June 1890, 160.

<sup>88</sup> Cited in LH Archive, Press Cuttings, A/26/5.

<sup>89</sup> C.Dainton, *The Story of England's Hospitals* (1961), 93.

<sup>90</sup> *Lancet*, 2 (1857), 650; Peterson, *Medical Profession*, 272-80.



rob the great hospitals of the support which they ought to receive'.<sup>91</sup> Specialist hospitals were shown to be the bloodsuckers of philanthropy and 'robbers of the poor'. However, even these institutions faced competition. When St.Martin's Hospital for Fistula opened in 1868, the older St.Mark's Hospital for Fistula immediately felt the economic consequences and beds were closed.<sup>92</sup> However, specialist hospitals were generally in a healthy financial position. In 1875 £106,385 went to 36 specialist hospitals with 113 beds, in the same year eight general hospitals with 2,268 beds received £110,199.<sup>93</sup> By 1887 the total deficit of the teaching hospitals exceeded £32,000, while the specialist hospitals had a surplus of £90,000.<sup>94</sup> For concerned contemporaries, this was a misapplication of resources. Part of the antagonism came from a sense of injustice as the specialist hospitals were invariably better at attracting direct philanthropy than their general counterparts. As the general hospitals had started to provide their own specialist departments from the 1850s onwards, competition was felt to be intensified. Specialist hospitals' general unpopularity as fraudulent institutions combined with deep-seated concerns about hospital finance to make them an unwelcome competitor for already limited resources.

The fickle nature of philanthropy and the intense competition within London's benevolent economy worried hospital administrators, especially as charitable resources fluctuated. In 1888, donations in London were an estimated £840,000; in 1890 they were £769,000.<sup>95</sup> Given charity's highly volatile nature, competition was a problem. It served to reduce the philanthropic income available to individual institutions on an annual basis, straining resources and encouraging at best a search for more reliable sources of income and at worse an anxious pursuit of funds.

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<sup>91</sup> *Hansard* (H of L), Vol. 338, 29 July 1889, col. 1551.

<sup>92</sup> Granshaw, *St Mark's*, 59; 70-71.

<sup>93</sup> *BMJ*, 1 (1877), 405.

<sup>94</sup> *Hansard* (H of L), Vol. 338, 29 July 1889, col. 1551.

<sup>95</sup> *Lancet*, 1 (1890), 97.

## 6. BENEVOLENCE IN THE NATIONAL ECONOMY

Britain's economic performance played an important role in controlling the flow of income to the London benevolent economy. A depression in industry or agriculture restricted the amount of income that was available to charity while periods of relative and perceived affluence encouraged the charitable public to give more and ensured that investments and land had a higher return. Fluctuations in the London economy made governors anxious rather than optimistic and often increased pressure on traditional resources. Under these conditions new sources of funding became desirable.

In 1895 the *BMJ* blamed the hospitals' financial troubles on the depression in industry. Depressions 'struck the well-to-do to a great extent', affecting 'the income of those who have been amongst the most prominent supporters of charities' and reduced charitable income as subscribers economised by giving less.<sup>96</sup> The journal predicted that 1895 would be an anxious year for hospitals.<sup>97</sup> It was not, however, an atypical year. Hospitals were 'exposed to the periodic recurrence of seasons of depression' and, according to Lord Aberdare, under such circumstances 'the difficulty of obtaining money is exceptional'.<sup>98</sup> Governors were all too aware of these problems. The governors of University College Hospital felt in 1887 that the hospital had suffered from the effects of the agricultural and industrial depression, which added to its 'life of struggling'.<sup>99</sup> In 1875 the governors of the German Hospital recognised that the uneasy feeling in the City would limit the flow of philanthropy and they withdrew £1,000 from their deposit account to cover the expected fall in charitable income.<sup>100</sup> Fluctuations in the nation's economic performance were not always damaging. Prosperous years could see an increase in direct philanthropy. In 1895 the Sunday Fund was able to distribute a record amount because

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<sup>96</sup> *Charity Record & Philanthropic News*, 7 (1887), 147.

<sup>97</sup> *BMJ*, 1 (1895), 31.

<sup>98</sup> *Lancet*, 1 (1877), 888; *Hospital*, 11 December 1886, 174.

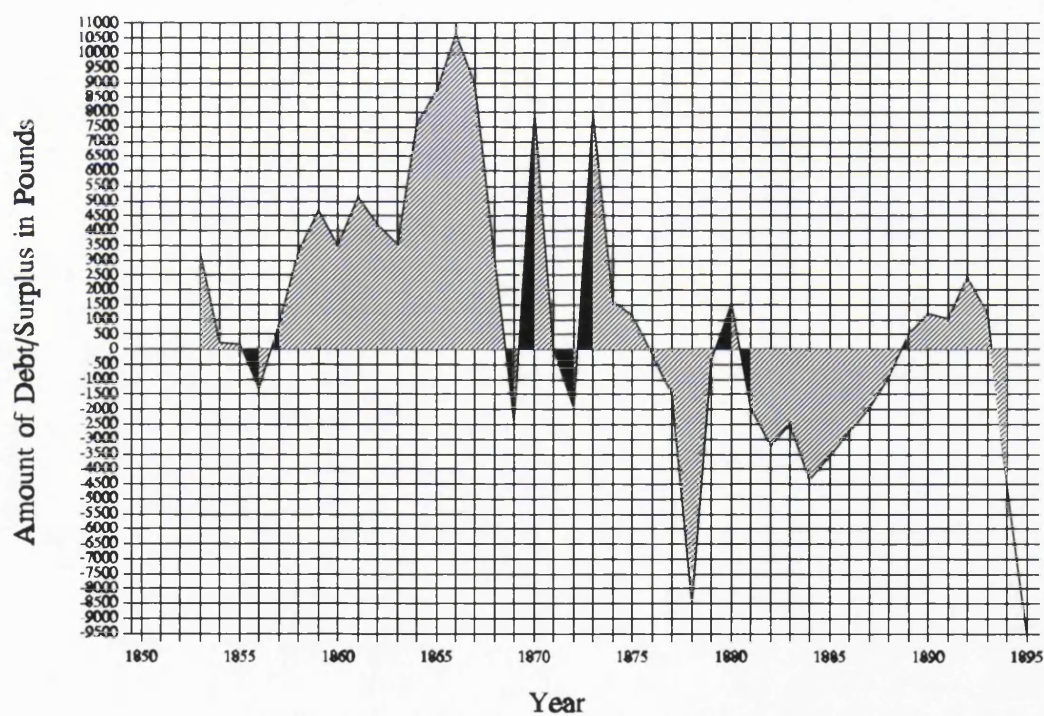
<sup>99</sup> *Charity Record & Philanthropic News*, 7 (1887), 147.

<sup>100</sup> GH Archive, Hospital Committee, A/2/6.

profits from the ‘South African Boom’ were partially redirected into the Fund.<sup>101</sup> However, such events were uncommon and it was more the problems faced by the national economy that worried governors.

Endowed hospitals were particularly susceptible to economic fluctuations. Direct philanthropy was not an accurate barometer of Britain’s economic performance, but land prices and the dividends, on which the endowed hospitals relied for the main part of their funding, were. This relationship was marked if the governors had invested unwisely. At St.Thomas’s and Guy’s a reliance on agricultural property produced a severe financial crisis from the late 1870s onwards.

Figure 4.7: Guy’s Hospital - Income Against Expenditure



Source: Guy’s Archive, Financial Abstracts, D19/1-3.

<sup>101</sup> See pages 97-8.

Agricultural prices had been falling since 1872, but it was not until 1879 that this began to deepen into depression. England's gross annual land value fell by 23.7% between 1879 and 1893, with the capital value falling by 50%.<sup>102</sup> The value of the estates Guy's held in Essex fell by 59% between 1889 and 1891, while the value of its estates in Herefordshire fell by 28%. In such a climate the governors could not dispose of the hospital's rural property. The effect on income can be seen by the level of debt generated at Guy's from 1876.

Financial problems were partly created by falling land values, but St.Thomas's and Guy's income was primarily affected by the declining ability of their tenants to pay their rent.

Table 4.3: Guy's - Income from Landed Property.

Year	Country Estates		Town Property	
	Gross	Net	Gross	Net
1875	£41,840	£30,919	£7,549	£6,533
1876	£41,679	£31,179	£7,977	£7,188
1877	£41,993	£31,396	£8,313	£7,567
1878	£40,367	£30,486	£7,888	£7,186
1879	£42,005	£33,421	£7,844	£7,177
1880	£41,379	£33,809	£8,109	£7,657
1881	£40,842	£25,983	£8,071	£7,512
1882	£39,399	£24,439	£8,111	£7,320
1883	£37,885	£26,281	£7,924	£7,150
1884	£35,186	£18,646	£7,993	£7,277
1885	£33,592	£20,612	£7,800	£7,193
1886	£31,938	£20,736	£7,622	£7,050
1887	£29,631	£19,504	£7,560	£6,852
1888	£31,210	£19,905	£7,639	£6,865
1889	£28,797	£18,652	£7,728	£7,154
1890	£28,191	£17,495	£7,634	£7,016
1891	£27,550	£17,222	£7,678	£7,035

Source: J.Steele, 'The Agricultural Depression and its Effect on a Leading London Hospital', *Royal Statistical Journal*, (1892), 12.

<sup>102</sup> RC on Agricultural Depression, *PP* 1897 XV, 22-23.

Initially, the governors attempted to ignore the problem as they felt that the situation was temporary and that recovery would be quick. However, after 1879 everything was attempted to stabilise income and one of Guy's governors stated before the 1897 Royal Commission on the Agricultural Depression that 'rentals have been greatly reduced, arrears blotted out, remissions given, large sums expended on buildings and in spite of it all, tenants are still unable to pay in full'.<sup>103</sup> Compromises were made at an individual level in the hope that by writing off part of a tenant's debt the rest might be repaid, but this policy was unsuccessful, leaving accumulating arrears.<sup>104</sup>

The *Lancet* was one of the few journals to recognise that the hospitals had 'fallen upon evil days entirely on account of [the] agricultural depression'.<sup>105</sup> Those outside the hospitals' administration, however, blamed the governors' financial mismanagement. At a meeting of the Sunday Fund in 1888, Dr Jabez Hogg claimed that Guy's had embarked on too ambitious a programme of speculation and this had left the hospital financially embarrassed.<sup>106</sup> The *BMJ* added that the financial position was a 'curious comment on late expenditure on the treasurer's house and the chapel'.<sup>107</sup> Bad luck was added to an already deteriorating position at Guy's. Damage to the sluice on the Lincolnshire property involved an 'unexpected' expenditure of £8,500, absorbing the £7,500 raised among governors and staff that Lushington had hoped to use to meet the hospital's debts.<sup>108</sup> With few resources to draw on, beds were initially closed at both hospitals and loans were negotiated. The financial situation became increasingly intolerable. With no tradition of appealing to the benevolent public, and in the face of the Charity Commission's refusal to sanction further borrowing, both hospitals attempted to solve the situation by admitting paying patients. The income from paying patients was insufficient to solve the hospitals' financial problems and in 1886 Guy's had launched its first public appeal to raise further

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<sup>103</sup> RC on Agricultural Depression, 9.

<sup>104</sup> Guy's Archive, Estates Committee, A22/1/1.

<sup>105</sup> *Lancet*, 1 (1896), 1651.

<sup>106</sup> Guy's Archive, Treasurer's Letter Book, A104/14.

<sup>107</sup> *BMJ*, 2 (1880), 855.

<sup>108</sup> *Graphic*, 14 May 1887, 514.

funds. St.Thomas's was quick to follow. Guy's and St.Thomas's had been reduced by financial circumstances to seek charity and in recognition the Sunday Fund included Guy's in its grants in 1887. Both hospitals now joined the non-endowed hospitals in competition for charitable resources at a time when they were diversifying their income away from direct philanthropy.

The situation at Guy's and St.Thomas's was severe. No other hospital was affected as dramatically by changes in the country's economic performance. New financial strategies were, however, forced on these hospitals by external economic factors, producing an anxious financial diversification. Guy's experiences highlight how hospital income was linked to factors outside London's benevolent economy as well as the strains acting on it. All hospitals encountered these pressures to a greater or lesser extent and this encouraged the pursuit of new sources of funding as traditional sources of income could not be relied on.

## 7. THE DAMNING EFFECT OF CRITICISM

Governors could not depend on the smooth flow of philanthropy to fund their institutions. The charitable resources available within the community and the benevolent economy were restricted and liable to fluctuate; the country's economic performance added an additional dimension. However, these were not the only problems. Governors faced a further difficulty as support could be alienated by criticism and scandal. According to the *Lancet* in 1881, there was growing disapproval of how the London hospitals were managed. The COS, Social Science Association, BMA, and the Hospital Association were at the forefront of this movement, though other bodies interested in hospital reform added their damning views. Given this critical environment, the benevolent, 'who were never too numerous', had ample '...reasons for buttoning up their pockets and withholding or reducing their subscriptions'.<sup>109</sup> The result was an alienation of support that was quickly translated into economic terms, increasing the pressure on the hospitals' already meagre resources.

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<sup>109</sup> *Lancet*, 2 (1881), 800.

Attacks on the voluntary system of medical relief reduced the subscribing public's confidence in the London hospitals, but certain campaigns had a noticeable effect. One example is the financial consequences of debate over vivisection, into which the London hospitals were unwittingly drawn. Passmore Edwards, a major philanthropist, claimed that the hospitals' finances were being damaged by the practice of vivisection. Although the *BMJ* dismissed the idea, the antivivisection lobby had some impact.<sup>110</sup> It is doubtful how many subscribers adopted Baroness Burdett Coutts's call in 1876 for a charitable boycott of those hospitals that employed vivisectionists, but the *Star* certainly felt that contributions would increase if the practice ceased.<sup>111</sup> By 1897 the government had only issued 86 vivisection licenses and there is little evidence to support the antivivisectionists' accusations that animal experiments were being funded by charitable contributions.<sup>112</sup> However, this did not stop the antivivisectionists from criticising hospitals with medical schools. In 1898 the London came under attack from the National Anti-Vivisection Society for its £2,000 subsidy to the medical college. The Society sent a letter to all the hospital's subscribers implying that the subsidy would be used to fund vivisection, pointing to the work carried out there by Leonard Hill and Harold Barnard on cats and dogs.<sup>113</sup> The hospital's governors were concerned enough to counter these accusations. Burford Rawlings, secretary to the National Hospital for the Paralysed and Epileptics, noted that antivivisectionists did 'their utmost to prevent subscriptions' to hospitals that they believed practised vivisection.<sup>114</sup>

Criticism was generally limited to individual hospitals. The press were quick to pick up on any scandal, blowing every minor incident out of proportion. Criticism damaged the hospital's standing with the public and governors did their best to avoid any scandal or sign of difficulty that would adversely affect their income. This was not

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<sup>110</sup> *BMJ*, 1 (1895), 1398.

<sup>111</sup> R.D.French, *Antivivisection and Medical Science in Victorian Society* (Princeton, 1975), 271; *Star*, 9 October 1896, 1.

<sup>112</sup> *Hospital*, 15 May 1897, 117-9.

<sup>113</sup> *Morning Leader*, 21 June 1898, 7.

<sup>114</sup> *Hospital*, 30 November 1895, 154.

always possible. At Guy's, the nursing dispute in 1880 damaged the hospital's public image and provoked an intense debate about the need for hospital reform, but the hospital's endowed income prevented public acrimony from being translated into economic hardship. The London and the German Hospital were not as fortunate when they were exposed to public censure in the 1890s.

Evidence given to the Select Committee on Metropolitan Hospitals and reports in the press concerning the London's nursing arrangements in 1890 provoked a crisis at the London that drastically affected the amount of charity received for that year. Some concern had been expressed when Eva Lückes was appointed matron in 1879 to reform the hospital's system of nursing. Some of the governors and members of the medical staff felt that she was too young and too pretty to be effective. However, as a close friend of Florence Nightingale she set about her work quickly and with zeal, dismissing the old nurses, selecting her own replacements and improving conditions. Both the staff and the governors supported her actions, probably because Lückes did not attempt to challenge their authority and limited her work to improving the standard of nursing. It was not until 1890, during the Select Committee on Metropolitan Hospitals, that differences and opposition became apparent. Witnesses accused the London of 'sweating' its nurses and exposing them to poor living conditions.<sup>115</sup> A disgruntled minority around Mrs Yatman, whose daughter had been a probationary nurse, and Mrs Bedford Fenwick, matron at St.Bartholomew's and wife of Dr Fenwick, the physician in charge of the nurses, savagely attacked Lückes's work. The Reverend Valentine, an embittered chaplain who had been dismissed in 1889 for ritualism and had promised to 'leave no stone unturned to do the Hospital injury', added his damning opinions.<sup>116</sup> Miss Yatman and several other nurses persistently claimed that the hospital had underfed and overworked its nurses for a pittance, a view corroborated by Dr Fenwick.

Fowell Buxton, the hospital's chairman, masterfully countered all the accusations levelled at the hospital, and apart from a small minority the governors and staff gave their 'unabated confidence in the administration of the Hospital'. Despite this, the governors were concerned that the hospital was 'being most unwarrantly damaged... in the

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<sup>115</sup> *Citizen*, 5 December 1891, 7.

<sup>116</sup> A.E.Clark-Kennedy, *London Pride* (1979), 142.



confidence of the public'.<sup>117</sup> The governors were alarmed because the hospital was under considerable financial pressure and needed public support. Certain sections of the press were scathing and even the *East London Advertiser*, normally a warm supporter of the hospital, was hostile. The *Pall Mall Gazette* in particular launched a virulent campaign and the *Hospital* felt that the editor had 'done his best to ruin the London Hospital'.<sup>118</sup> Personal animosity animated much of the dispute, but the effect was not lost on the subscribers. Income fell by £10,000 and the hospital had to sell part of its invested stock to meet the deficit.<sup>119</sup> Although the charges were eventually proved false and the Lord's committee returned a generally favourable verdict on the hospital, the London suffered financially.<sup>120</sup> Efforts were made to restore public confidence, but income from direct philanthropy took several years to return to its pre-1890 level and in the meantime the governors had to borrow more money.

At the German Hospital an internal crisis two years later had similar economic consequences. Accusations surrounding the chaplain's Lutheran proselytism sparked a controversy that offended Jewish and Catholic subscribers. The hospital had been founded on liberal principles, but Baron Schröder's statement as chairman at the governors' annual meeting in 1894 contradicted this sentiment. In response to a question from the Rector of the Roman Catholic Church of St. Boniface, Schröder declared that the hospital was 'decidedly a protestant institution'.<sup>121</sup> Complaints had been made earlier in the year that Catholic patients had been forced to attend services in the Lutheran Church next to the hospital and that Gülich, the hospital's superintendent, had prevented a Catholic patient from receiving the last rites. Both events were contrary to rule 26 that clearly stated that all patients had the right to their own minister. Between January and May 1894 accusations of proselytism were brandished in the press. A number of governors resigned over the issue and Dr Ludwig, a physician at the hospital, left because he felt his position

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<sup>117</sup> LH Archive, Court Minutes, A/2/14.

<sup>118</sup> *Hospital*, 5 August 1893, 290.

<sup>119</sup> *Hospital Gazette*, 5 March 1892, 119; *Morning Post*, 26 December 1891, 4.

<sup>120</sup> SC on Metropolitan Hospitals, 3rd Report, PP XIII 1892, xvi-xx.

<sup>121</sup> GH Archive, Annual General Court, A/4/2.

under such a regime was ‘inconsistent with my dignity’ and because the governors found his attacks on the hospital’s poor treatment of Jews unacceptable.<sup>122</sup> The local Jewish community supported Ludwig’s accusations and Davidson, Chairman of the Visitation Committee of the United Synagogue, considered breaking the Synagogue’s connection with the hospital and sending its sick to the Metropolitan Hospital. A heated special meeting attacked the hospital’s protestant bias, and by a majority of 38 a motion was passed that confirmed the hospital’s non-sectarian nature.<sup>123</sup> The dispute ended, but not without damaging the hospital’s subscriptions. The *Charity Record & Philanthropic News* noted that such proselytising meant ‘goodbye to... generous and sympathetic support’.<sup>124</sup> Donations fell from £3,253 16s 8d in 1892 to £2,695 14s 5d in 1893, recovering only slightly in 1894 once the dispute had ended.<sup>125</sup> The governors fought shy of mentioning the dispute in the 1894 Annual Report as they were afraid that support might be damaged still further.

Contemporaries were aware of these problems, and hospital scandals remained a constant theme in the press. The consequences were rarely disastrous, but they were often serious enough to provoke alarm and forced governors to rely more heavily on non-charitable sources of funding. As the *Hospital* wrote in 1893, hospitals needed ‘less criticism and more cash’.<sup>126</sup>

## 8. CONCLUSION

The problems facing hospital finance were varied. It is perhaps because hospitals did not rely on any one source of income, but developed a diverse financial base that they managed to survive expansion and the transition away from a purely philanthropic base. The need to develop new sources of funding was always present. Financial diversification

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<sup>122</sup> GH Archive, Hospital Committee, A/2/9.

<sup>123</sup> GH Archive, Annual General Court, A/4/2.

<sup>124</sup> *Charity Record & Philanthropic News*, 14 (1894), 201.

<sup>125</sup> German Hospital Annual Report, 1892-1894.

<sup>126</sup> *Hospital*, 3 June 1893, 153.

was in part inspired by the restricted nature and uncertainties of direct philanthropy, but was linked to the hospitals' experiences as a medical institution, their location, nature and expenditure. However, perhaps it should be recognised that invariably it was the opportunity to move away from traditional sources of funding that sealed the hospitals' financial strategy. Without the opportunity to charge probationary nurses, redirect clinical fees, even sell land or make public appeals, the hospital had to struggle on with its traditional resources until a solution was found. Such an important transformation in the hospitals' financial character and a dilution of charity's significance in the structure of income, raises questions about the how financial diversification influenced the hospitals' administration and it is these issues that the next section addresses.

## **Part II: Philanthropy and Control**

## Charity and Control - Lay Administration of the Hospital

### 1. NATURE OF HOSPITAL ADMINISTRATION

The diversification of income and a dilution of charitable resources in the London hospitals' structure of income discussed in the previous section did not occur in a vacuum. At the same time as the hospitals' funding was changing, the administrative environment also altered. It would be convenient to link the two: to argue that a change in finance encouraged a dilution of the philanthropists' power. Does such a view match the evidence?

Abel Smith has argued that nineteenth-century hospital administration represented an idiosyncratic mix of institutional variations.<sup>1</sup> Differences did exist and each hospital developed its own administration to match its institutional needs, but it would be true to say that hospitals conformed to a certain managerial norm; that hospitals in Wakefield, Bristol or Chichester had a similar administrative structure as their counterparts in London.<sup>2</sup> Just as similarities existed between hospitals, they also existed between charitable agencies. According to Morris, by the 1830s voluntary societies had emerged as a flexible and adaptable 'cultural norm', sharing a number of organisational features.<sup>3</sup> Hospitals fitted within this pattern and shared common characteristics with other benevolent societies.

Charitable organisations were governed by a 'subscriber democracy', where 'one subscriber, one vote was the general rule' and membership was limited to those who contributed.<sup>4</sup> The hospital's voluntary nature was reflected in its management, but the 'subscriber democracy' was modified in favour of a hierarchical administrative system.

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<sup>1</sup> B. Abel Smith, *The Hospitals 1800-1950* (1964), 34.

<sup>2</sup> H. Marland, *Medicine and Society in Wakefield and Huddersfield 1780-1870* (Cambridge, 1987), 98-9.

<sup>3</sup> R. J. Morris, *Class, Sect and Party: The Making of the British Middle Class, Leeds 1820-50* (1990), 184.

<sup>4</sup> Morris, *Class, Sect and Party*, 184.

Authority continued to be vested in the subscribers, with the presidents and vice-presidents remaining largely ornamental. However, though the subscribers retained the theoretical right to influence the hospital, in practice managerial responsibility was awarded only to those who had contributed a certain amount. Ten guineas represented the minimum contribution for a position on the hospital's management, but some institutions set a higher premium: at the Hospital for Sick Children, for example, £52 10s was expected. These subscribers became the hospitals' governors. Where the medical profession was crucial in the provision of voluntary healthcare, they remained subordinate to the governors who controlled the hospital. Management based on subscriber representation would have created enormous logistical problems when thousands were encouraged to contribute. By limiting the number of governors through a monetary qualification, a smaller administrative unit was created. Doubts existed about whether this was the most rational basis for management, but it was widely accepted as the best system that could be devised.

The endowed hospitals further modified institutional charity's managerial norm and substituted nomination for subscription. St.Bartholomew's, St.Thomas's and Guy's had no large body of subscribers as they relied, at least until the 1880s, on endowments for their financial security.<sup>5</sup> With few philanthropists involved directly in the hospitals' funding an alternative basis of management had been created. The small number of benefactors and the high contribution required for a governorship ensured that the administration was a self-perpetuating oligarchy, selecting its own candidates for inclusion.<sup>6</sup> At Guy's, where the number of governors was limited to sixty, this system gave the hospital the strong Evangelical character noted in Chapter 2. Nomination, however, produced few active governors. Under these circumstances the hospitals' main administrative duties passed to a treasurer, as each hospital's only permanent lay official. At Guy's the post was residential. Treasurers were appointed at other hospitals, but they did not adopt the same prominent role that they served in the endowed hospitals. The governors at St.Bartholomew's and Guy's, without an active financial interest in the

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<sup>5</sup> See pages 166-9.

<sup>6</sup> At St.Bartholomew's governorships cost £100 in 1864: SBH Archive, Governors' Minutes, Ha/1/22.

hospital, seemed content to let the treasurer run the institution. From the 1850s onwards the medical press was concerned that such a system encouraged autocracy. Until the appointment of Sydney Waterlow at St.Bartholomew's in 1874 and Edmund Lushington at Guy's in 1876, it was not so much autocracy that was characteristic, but inactivity. Endowed hospitals had a poor record of reform and much of this can be attributed to their governors' disinclination to become actively involved in the hospital's management.

The notion that financial commitment was naturally linked to managerial responsibility was a powerful concept in the administration of benevolent societies. However, at St.Bartholomew's and University College Hospital an external non-elected authority claimed an influence in each hospital's affairs. St.Thomas's had managed to shake off the City of London's influence by 1782, but at St.Bartholomew's the City retained the right to appoint aldermen and the lord mayor as governors.<sup>7</sup> Aldermen, except Waterlow, did not display much interest in the hospital and remained a minority group, but the City was keen to exercise its privilege and took St.Bartholomew's to court in 1863 when it felt that its rights had not been upheld. The City won the case, taking the moral high ground that they had a right to appoint governors as they had in the past made substantial contributions.<sup>8</sup> At University College Hospital, University College London, the founding influence behind the hospital, appointed the College Secretary as an ex-officio officer on the Management Committee.<sup>9</sup> Through the secretary the College's interests were protected, but he was disinclined to participate in the hospital's affairs. In both cases the rhetoric of financial support was used to justify involvement.

All hospitals organised their governors into a general court that sat periodically to discuss the institution's business. The frequency of these meetings varied between hospitals: most met on an annual basis at the start of the Season when governors were guaranteed to be in London, though at the Hospital for Sick Children and St.Bartholomew's the court assembled every three months. The responsibilities of the

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<sup>7</sup> L.Granshaw, St.Thomas's 'Hospital, London 1850-1900' (Unpublished PhD Thesis, Bryn Mawr College, 1981), 57; V.Medvei & J.Thornton, *The Royal Hospital of St.Bartholomew's 1123-1973* (1974), 23.

<sup>8</sup> *Medical Times & Gazette*, 2 (1863), 472.

<sup>9</sup> UCH Archive, Medical Committee, A1/2/1.

general court, as outlined by the Charity Commission in 1840, remained unchanged throughout the nineteenth century. Courts convened to appoint 'the presidents, treasurers, and all other officers and ministers... and to do every other act of good government'.<sup>10</sup> Important decisions, especially those linked to finance and appointments, required a special meeting. General courts could provide the opportunity for intense conflict, as seen at the German Hospital in 1894 over the hospital's religious character, but mainly they remained quiet and orderly, a chance to review the year's work.<sup>11</sup> The unwieldy nature of these bodies required an administrative streamlining. Managerial responsibility was transferred to an annually elected committee, a move that *Charity* felt in 1887 promoted the most efficient form of management.<sup>12</sup> Contemporaries feared that this would encourage subservience to the hospitals' permanent officials, but instead administration passed to a small clique. The general court remained a hospital's ultimate executive authority, but management had effectively devolved to its elected representatives.

Management committees met weekly, or every two weeks, and discussed every administrative detail. The names of these bodies changed at each institution: at Guy's the main management committee was called the Court of Committees, at the German Hospital the Hospital Committee, while at the London the hospital was administered by the House Committee. The functions of these committees, however, remained the same. All major decisions had to be referred back to the general court, but as the management committees consisted of the leading governors, and the courts generally gathered annually and were poorly attended, they shaped the hospitals' development. Some critics felt that this produced a closed shop and made a farce of elections, echoing similar criticisms made of local government.<sup>13</sup> The same men were returned year after year, ensuring a certain degree of continuity, though not all took up their posts with equal enthusiasm. Whereas Sir Francis Goldsmid was the tireless chair of University College Hospital, Robert

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<sup>10</sup> 32nd Report of the Charity Commission, *PP* 1840 XXIX, 9.

<sup>11</sup> See pages 173-4.

<sup>12</sup> *Charity*, April 1887, 217.

<sup>13</sup> *Times* 26 December 1889, 9; J.Garrard, *Leadership and Power in Victorian Industrial Towns 1830-1880* (Manchester, 1983), 79.



Hawthorn, after his appointment as a governor in 1850, never attended a meeting.<sup>14</sup> To promote continuity at the German Hospital, the Hospital Committee was chosen from the eighteen most active members of the previous year's committee. Six new governors were elected to the committee annually to prevent stagnation, but in 1854 this was reduced to three.<sup>15</sup> Committees were invariably poorly attended and small quorums were specified in the hospitals' rules to compensate. At the Hospital for Sick Children, the Committee of Management had a membership of twenty and a quorum of seven, but meetings periodically had to be cancelled due to poor attendance.<sup>16</sup> It was a common problem. In hospitals 'the work of very many is performed habitually by the attendance of the same four or five'.<sup>17</sup> From among this small group, a chairman was elected who became the hospital's spokesman and a guiding influence in the administration. Chairmen did not acquire the same degree of influence that the treasurers of the endowed hospitals possessed; their authority was moderated by the larger number of governors who were willing to become actively involved in the hospital's administration. However, chairmen did wield considerable influence by virtue of their long standing attachment to the institution and their willingness to attend every meeting.

Not all issues were discussed by the entire committee. Matters requiring detailed investigation were delegated to subcommittees. At St.Bartholomew's and University College Hospital, management via subcommittee became the main vehicle for administrative change; at other hospitals they were established periodically to discuss a wide range of issues. At the German Hospital a subcommittee was appointed in 1851 to look into the purchase of a portrait of the Duke of Cambridge, the hospital's president; at the London subcommittees were convened to discuss, for example, the employment of a new chaplain in 1889 or building plans in 1890.<sup>18</sup> These subcommittees could become

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<sup>14</sup> UCH Archive, General Committee, A1/2/1.

<sup>15</sup> GH Archive, Annual Court, A/4/1.

<sup>16</sup> GOS Archive, Staff Rules, GOS/5/1/3a.

<sup>17</sup> *Times*, 11 December 1850, 4.

<sup>18</sup> GH Archive, Hospital Committee, A/2/2; LH Archive, Subcommittees, A/9/122; Court Minutes, A/2/14.

a semi-permanent feature of the administration. The annual dinner and the organisational activity needed to make it a success saw the formation of dinner committees, elected annually for short periods of time. The flexible nature of such committees ensured that they were adapted to organise a number of fundraising activities. Where building occurred over several years, as at the Hospital for Sick Children, building committees met until the work was completed.

Management committees did not supervise the hospitals' day-to-day administration. In industry owners delegated the immediate management of the workshop or factory to trustworthy employees, ensuring a minimal bureaucratic framework. According to Hannah, it was only after 1914 that industry moved away from its family basis and started to develop the factory office as more than an adjunct to the workshop.<sup>19</sup> In hospitals, a similar process of delegation occurred, but here governors exercised a higher degree of control through regular visits to the wards and a system of reports. Medical responsibility on a daily basis was delegated at a ward level to the matron and at a wider level to the doctors who were expected to submit regular reports to the governors. Other administrative duties were allocated to other employees. Paid collectors working on commission, collected subscriptions and, where large estates were held a land agent was employed. Paid administrators were appointed, for it was 'unreasonable to expect a gentleman either in business or out of business, to devote sufficient time' to the hospital's daily management.<sup>20</sup> The names for these posts varied, the work remained the same. According to the *Charity Record & Philanthropic News* a secretary had to be 'a man of business, a good accountant and bookkeeper, a diplomat, special pleader, architect and builder, a house steward, tinker, clerk of the works, and occasionally office boy and porter'.<sup>21</sup> No chairman or treasurer, even when residing in the hospital, could be expected to carry out all these duties. Administrators generally had a colonial or civil service background and were indefatigable in their efforts; much of the Hospital for Sick Children's success was linked to the tireless work of Adrian Hope, the hospital's secretary from 1885 to 1904. Constant attendance ensured that these posts were salaried.

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<sup>19</sup> L.Hannah, *Rise of the Corporate Economy* (1983), 71-72.

<sup>20</sup> Granshaw, 'St.Thomas's', 49-51.

<sup>21</sup> *Charity Record & Philanthropic News*, 12 (1892), 214.

Administrators earned between £100 and £400 per annum, a rate of pay that compared favourably with local government officers' salaries in 1914 where 88% were paid below £260.<sup>22</sup> However, from the 1880s onwards administrators increasingly complained about their poor level of pay. Governors gradually responded by raising salaries, appointing additional clerks and creating new posts by dividing the secretaries' duties, pointing to an increased professionalisation in hospital management. Nevertheless hospitals continued to be managed by governors and not by paid administrators even in 1900. An attitude that favoured a professional and bureaucratic administration was slow to emerge. Hospitals remained bastions of amateurism where other organisations were moving towards a professional management structure and professional administrators were taking a key role in social-reform organisations.<sup>23</sup>

## 2. ADMINISTRATIVE CHANGE

The transition from a philanthropic imperative to a medical environment was marked by a change in the hospitals' administrative structure. Wards were added, outpatients' departments were built and telephones were gradually connected.<sup>24</sup> The institutional environment under which hospitals had initially grown was ill-suited to the process of medicalisation. The result was administrative expansion, rather than a fundamental change in how the hospital was managed.

The 'ostentatious worship of the voluntary system' persisted in hospital management.<sup>25</sup> The existing administrative environment was modified, but within the

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<sup>22</sup> P.Waller, *Town, City and Nation* (Oxford, 1991), 286.

<sup>23</sup> J.Harris, 'Political Thought and the Welfare State 1870-1949: An Intellectual Framework for British Social Policy', *Past and Present*, 134-5 (1992), 122.

<sup>24</sup> The Hospital for Sick Children was particularly slow on the last point, the Management Committee only started to discuss the need for a telephone in 1896, while the House and Finance Committee at University College Hospital had one connected in 1883: GOS Archive, Committee of Management, GOS/1/2/21; UCH Archive, House & Finance Committee, A1/3/2. These technological changes were in advance of many businesses as in general, office technology remained crude until after 1914: Hannah, *Rise of the Corporate Economy*, 77.

<sup>25</sup> *Times*, 2 August 1892, 11.

parameters of voluntarism. Rather than altering the hospitals' charitable foundation, the governors adapted and extended the administration, because an alternative to voluntarism was unthinkable in a society where philanthropy and amateurism were revered. Existing committees were modified; new functions were grafted onto old committees and through a process of organisational subdivision new committees were created.<sup>26</sup> St.Bartholomew's stood apart from these developments, limited by its royal charter and constrained by the institution's conservatism. The House Committee's work increased from the 1870s onwards and a series of subcommittees were appointed to discuss specific administrative and medical changes, but no new committee was formed until 1892. At other hospitals, to prevent an unmanageable structure from emerging, an administrative subdivision occurred as management became too complex for one committee to encompass.

General hospitals founded in the institutional expansion of the eighteenth century and the teaching hospitals of the early nineteenth century were the first to expand their administration and growth took place before 1850. The new specialist hospitals followed. Development was often linked to an increase in the institution's size and duties, and most committees were added after periods of building. Doctors were often at the centre of these developments. However, as explained in Chapter 6, where the medical staff might encourage the hospital's expansion, at best they were able to obtain a junior partnership in the hospital's formal administration. In response to change, lay finance committees were created to control the hospitals' increasing expenditure; house committees were set up to regulate 'house keeping and drug expenditure, furniture and repairs etc., the hiring and discharge of servants and nurses' and to 'take the responsibility [for] the internal management of the institution'.<sup>27</sup> Estate committees were founded to supervise the hospitals' property, and medical committees were established by doctors to help regulate the hospitals' medical environment. The new committees invariably met monthly and submitted regular reports outlining their suggestions to the management committees, which

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<sup>26</sup> These changes were reflected in a transformation of the nature of record keeping. Narrative accounts began to disappear from the annual reports and new systems of records were established: B.Craig, 'A Survey and Study of Hospital Records and Record Keeping in London (England) and Ontario (Canada) c. 1850 to c. 1950' (Unpublished PhD Thesis, University of London, 1989), 164.

<sup>27</sup> RCH Archive, House Committee, A4/1.

would make the final decision. Invariably agreement was a foregone conclusion as the new committees were subsets of existing committees. As a result, the management committees were freed from many of their duties, and though they retained responsibility for all the decisions made, they were involved in less administrative detail.

Administrative expansion is best illustrated by the experiences of the Royal Chest Hospital. The admission of inpatients in 1850 strained the established managerial structure and in 1853 the Management Committee appointed a subcommittee to investigate the administration. No immediate changes were made, but in 1857 the Management Committee abandoned its quarterly meetings at the London Tavern, Bishopsgate, and met monthly at the hospital.<sup>28</sup> The decision to extend the hospital in 1862 prompted further changes. A Building Committee was appointed and a Finance Committee was established to raise money for the venture.<sup>29</sup> The opening of the new hospital saw further development. In 1864 Robert Smart, the secretary, was awarded £10 for his extra work and in 1866 an honorary secretary was appointed to assist him. To manage the new domestic arrangements a House Committee was formed and after a probationary period of three months it was made permanent. In 1867 an auditor was appointed to help manage the hospital's finances.<sup>30</sup> By 1881 the hospital's management had increased sufficiently for the secretary to be awarded a £150 pay rise, and in 1885 an Election Committee was established to discuss staff appointments, followed by a Drug Committee in 1886. The result was a dramatic increase in the hospital's running expenses and in 1886 the Sunday Fund felt disinclined to award the hospital a full grant.<sup>31</sup>

Similar developments can be seen at other hospitals. The Hospital for Sick Children was managed solely by the Management Committee until 1858 when Finance, Dinner and Drug Committees were added.<sup>32</sup> By 1878, the hospital was governed by eight

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<sup>28</sup> RCH Archive, Governors' Minutes, A1/3.

<sup>29</sup> RCH Archive, Governors' Minutes, A1/2.

<sup>30</sup> RCH Archive, Governors' Minutes, A1/3.

<sup>31</sup> RCH Archive, Governors' Minutes, A1/5; 6.

<sup>32</sup> GOS Archive, Committee of Management, GOS/1/2/6.

committees and a Chapel Committee was established in 1891.<sup>33</sup> Administrative expansion was not limited to the specialist hospitals, but at the general hospitals physical expansion was less of a factor in development. New committees were founded at these hospitals in response to specific concerns. The London, anxious about its financial position in 1864, founded a Finance Committee and when the governors made a financial commitment to the Medical College a Joint College Board was formed in 1876.<sup>34</sup> The retirement of a long-serving treasurer or chairman provided a chance to reevaluate the hospitals' management. At Guy's the administration was investigated in 1896 when Lushington retired. The difficulty of finding a replacement saw a change in how the hospital was governed. The treasurer's post was made non-resident and a new administrative structure was adopted.<sup>35</sup> A School and Staff Committee was established to deal with the hospital's medical arrangements and a House Committee was set up to concentrate on domestic affairs.<sup>36</sup> Concern over the hospital's poor financial position saw the foundation of a Finance Committee to coordinate fundraising and the Act of Incorporation was modified in 1898 to increase the governors' control over the hospital's landed property.<sup>37</sup> The immediate effect was an increase in activity and the governors became less inclined to let the treasurer make all the decisions. Comparable changes were made at the London in 1897 when Sydney Holland was made the hospital's chairman.<sup>38</sup>

A static administrative structure could not support a change in the nature of the hospital. Medicalisation, building, and financial anxiety required bureaucratisation and administrative expansion. Gradually duties were devolved from the main management committee to smaller bodies to cope with the increase in the hospitals' functions and work. Simultaneously specialist paid staff were appointed to deal with the hospitals'

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<sup>33</sup> GOS Archive, Committee of Management, GOS/1/2/20.

<sup>34</sup> LH Archive, House Committee, A/5/32; 37.

<sup>35</sup> Guy's Archive, Court Minutes, A1/4.

<sup>36</sup> Guy's Archive, Staff & School Committees, A23/1; Agenda Books, A25/1

<sup>37</sup> Guy's Archive, Finance Committee, A24/1.

<sup>38</sup> A.E.Clark-Kennedy, *The London* (1963), 127-136.

day-to-day management. The result was an increase in administrative complexity and the development of a more organised and efficient approach to hospital management. The emphasis, however, remained on voluntarism.

### 3. THE SUNDAY FUND'S INFLUENCE ON HOSPITAL MANAGEMENT

Governors resisted any external pressure for reform. However, the Sunday Fund used the governors' own rhetoric of financial commitment and managerial responsibility in its attempt to reform hospital management. Rivett, in describing the Fund as an attempt at 'systematising hospital organisation', reflected contemporary judgements.<sup>39</sup> The *Lancet* maintained that the Fund was bound to 'exercise a most powerful influence on all points connected with hospital management' as 'advice to charitable institutions comes with most force when it is accompanied by assistance'.<sup>40</sup> It was an opinion that acted as the mainstay of the journal's support. Hospital reformers initially praised the Fund for its reformists intentions and allied themselves with the movement to further their aims. Sydney Waterlow was quick to confirm the Fund's potential, stating that by 'holding the power of the purse in the name of the public we have an influence over them [medical charities] which it would be difficult to exercise in any other way'.<sup>41</sup> At the grass roots level similar ideas were discussed. For example, in 1880 the Hammersmith branch stressed the need to extend the Fund's investigative and reforming potential, especially over the geographical distribution of hospitals.<sup>42</sup> Policy was not as clear cut as this, but within the Fund there was an awareness that it represented a positive instrument for intervention. Reformers predicted that its activities would solve the more obvious problems in hospital management. From the start the COS saw the Fund in these terms and attempted to influence its policy.<sup>43</sup> In fact, both organisations had similar intentions.

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<sup>39</sup> G.Rivett, *Development of the London Hospital System 1832-1982* (1986), 121.

<sup>40</sup> *Lancet*, 1 (1875), 247; 2 (1874), 22.

<sup>41</sup> Cited in D.Owen, *English Philanthropy* (Cambridge, Mass., 1964), 486.

<sup>42</sup> *BMJ*, 2 (1880), 892.

<sup>43</sup> Rivett, *Development of the London Hospital System*, 122.

The COS strove to reform and organise charity; the Sunday Fund wanted to reform hospitals and organise collections. However, the COS's brand of organisation was resisted and Waterlow persuaded the Fund's committee that the COS's ideas were not relevant to the Fund. In the face of opposition, the COS's enthusiasm waned and it diverted its attention to the foundation of a central hospitals board.<sup>44</sup>

The Fund initially justified the reformers' hopes. Management was vested in a Council, consisting of fifty clerical and fifty lay members who elected a Distribution Committee to conduct the main work of the Fund. It replaced the individual's choice of philanthropic outlet with careful investigation. The Fund's rules provided the basis for distribution. Rule eight stipulated that only hospitals that produced printed reports with an audited balance sheet for three years were entitled to consideration. The endowed hospitals, with which many of the initial organisers were associated, were therefore excluded as they made no attempt to publicise their finances outside the hospital.<sup>45</sup> Grants were based on two calculations: the cost of inpatients per bed, and the cost of outpatients per head. These were determined by matching expenditure against the number of patients treated. Those institutions found to be too expensively managed were penalised or even excluded to encourage reform. In the distribution of collections the Fund departed from the established 'cultural norm' for a benevolent society. Authority continued to come from a well publicised annual general meeting that elected a committee of management, but the mass subscribing public was denied the right to dictate how their contributions would be used. It was perceived that the subscribers' right to influence the hospitals' administration had not solved the hospitals' problems. The Fund therefore removed the subscribers from their potentially influential position and substituted itself as the agent of reform. The Distribution Committee sought to replace the active citizen's arbitrary choice of destination for his philanthropy with a centralised system based on the careful investigation of each hospital's benefit to the community. Those giving to the Fund had to place their faith in the fact that it would distribute the grants wisely.

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<sup>44</sup> See Chapter 8.

<sup>45</sup> Guy's applied in 1887 as the hospital's financial circumstances forced it to conform to the Fund's notions, but St. Thomas's did not approach the Fund until 1896 and was prevented from participating as the governors would not agree to the Fund's uniform system of accounts or public audit: *Hospital*, 1 August 1896, 397.



Awards were well publicised and because they were from a body that claimed to distribute money on the grounds of utility, hospitals were exposed to comparison and public scrutiny, thereby encouraging reform. A small grant or a fall in the award was viewed with considerable anxiety, as this created an impression of poor management.<sup>46</sup> The Metropolitan Free Hospital felt so strongly about its low grant in 1874 that the hospital's authorities protested violently, complaining of corruption, but made no effort to reform its own management.<sup>47</sup> Those concerned with the position of the specialist hospitals attempted to use the Metropolitan Free Hospital's grievances to hijack the Fund and impose their own views on distribution, involving the Fund in an acrimonious public debate that threatened collections.<sup>48</sup> Other hospitals responded in a positive manner, showing the movement's potential as an instrument for reform. When the Royal Chest Hospital was awarded £82 in 1875, £50 less than in 1874, the governors held an investigation and conducted a programme of strict reform. The governors made strenuous efforts to reduce advertising costs, pursue lower tenders, and even added two beds to lower the average cost per bed.<sup>49</sup> Grants rose accordingly. This was exactly what the Fund and its supporters hoped to accomplish.

The Sunday Fund ultimately disappointed hospital reformers. Increasingly it became exclusively 'a collecting body', assuming a less interventionist stance, and the mantle of reform passed to other organisations. Some progress was made in encouraging the adoption of a uniform system of accounting. This was crucial to the Fund's work in allowing an effective comparison of institutions that had previously misguided the public with idiosyncratic balance sheets, but by 1892 efforts were still being made to promote uniformity.<sup>50</sup> Hospitals, however, were slow to adopt the Fund's suggestions. It was not until 1894 that the German Hospital started to audit its accounts under financial pressure

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<sup>46</sup> In effect this was a forerunner to the recent moves to publish 'league tables' to allow the public to make 'informed' comparisons on services.

<sup>47</sup> *Times*, 16 September 1874, 8.

<sup>48</sup> *Times*, 17 December 1874, 8; *BMJ*, 2 (1875), 372.

<sup>49</sup> RCH Archive, Governors' Minutes, A1/4.

<sup>50</sup> *Times*, 18 December 1890, 10; *Hospital*, 30 January 1892, 223.

from the Fund.<sup>51</sup> St.Thomas's, as noted, even disqualified itself from the Fund's support by refusing to adopt the uniform system of accounts.<sup>52</sup> An inability to secure effective reform was not just seen over account procedures. Even the pressing issue of hospital abuse, where an increase in admissions was misconceived as a growth in the number exploiting charity, was not dealt with effectively. The issue had emerged in the 1850s, but it was not until 1897, after five years of investigation, that the Fund started to encourage governors to appoint inquiry officers to investigate patients' social backgrounds after their first visit to reduce abuse.<sup>53</sup> The *Lancet* was disenchanted by 1897 and concluded that Waterlow 'has become increasingly reluctant to see the growing abuse of hospitals, which to everyone else is so apparent, and to use the great power of the Council of the Hospital Sunday Fund for its friendly correction'.<sup>54</sup> Waterlow's unenthusiastic attitude was symptomatic of developments within the movement.

Two currents can be detected in the Sunday Fund's change in attitude. The philanthropic public, assaulted by a multitude of charitable appeals, lacked the resources necessary to meet the London hospitals' spiralling expenditure. The Fund was all too aware of this dilemma. Initially it had to balance the need to solve the hospitals' economic problems with the desire for reform. By the 1880s an apparent financial crisis in the London hospitals blinkered the Fund to the need for reform and consequently it became absorbed in the problems of hospital funding. This combined with a selfish desire to maximise its own income as a justification for its existence.

Intervention also carried its own dangers. A preoccupation with hospitals' internal management held the potential of alienating vested interests. It was a position that the Fund hoped to avoid to ensure its continued popularity. This was highlighted in 1885 when the grant awarded to University College Hospital was attacked. Critics felt that the grant had been ill-advised as the hospital employed the Anglican All Saint's Sisterhood

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<sup>51</sup> GH Archive, Hospital Committee, A/2/9.

<sup>52</sup> *Hospital*, 1 August 1896, 397.

<sup>53</sup> *BMJ*, 2 (1897), 1821.

<sup>54</sup> *Lancet*, 1 (1897), 672.

to organise nursing.<sup>55</sup> Concern was purely sectarian as the nursing at University College Hospital was highly efficient. The Fund's General Purposes Committee investigated and concluded that 'matters relating to the internal administration of hospitals are beyond the jurisdiction of the Hospital Sunday Fund'.<sup>56</sup> This was a complete rejection of the movement's initial reformist intentions.

The transition from a reforming body to a funding body occurred at no definable point, but from the 1880s the Fund expected increasingly less from the hospitals it supported. The model, however, was not abandoned but revitalised in the Prince of Wales Hospital Fund, which, as shown in Chapter 8, reoriented the nature of active philanthropy.

#### 4. HOSPITAL MANAGEMENT: AN ASSESSMENT

The voluntary system that the London hospital embraced was seen as the best possible system of administration, free from state interference and capable of promoting a friendly and homely atmosphere. Hospital reformers, the COS, the Hospital Association, and the Social Science Association did not question the merit of voluntarism, but they readily found fault with its existing administration. The *Lancet* believed that 'the whole system of Hospital Government is as bad, as injurious, and as defective as is possible to be conceived'.<sup>57</sup> For the *Hospital* in 1894

it is strange that principles of common sense and business prudence as yet gained so little ground among English charitable institutions, managed and supported as they are by businessmen who would shudder at the thought of ordering their private affairs on the lines of incessant debt and difficulty.<sup>58</sup>

Complaints were often generalised, but individual hospitals became the subject of violent attacks by the press that often had dramatic consequences for their finances, as noted in

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<sup>55</sup> *BMJ*, 2 (1885), 266.

<sup>56</sup> *Times*, 2 December 1885, 7.

<sup>57</sup> *Lancet*, 2 (1853), 252.

<sup>58</sup> *Hospital*, 7 June 1894, 303.

Chapter 4. The endowed hospitals were particular targets for criticism. The closed nature of the administration at St.Bartholomew's alarmed contemporaries. In 1869 the *Lancet*, in support of the medical staff's calls for an ophthalmic department, felt that the governing body was a 'close[d] corporation'. However, it understood that any 'charge' would 'doubtless be opposed, because rich aldermanic governors will not be disposed to yield the opportunity of toadying wealth and social position'.<sup>59</sup> The medical press followed the *Lancet*'s lead, though conservative sections of the press felt that St.Bartholomew's was 'a most admirably managed establishment'.<sup>60</sup> To defend itself, the hospital held a public meeting presided over by the Prince of Wales. Foster White, the treasurer, made vague promises of improvement and the Prince called for the more active involvement of the governors. Limited medical changes were made, but the hospital's administration remained unaltered.<sup>61</sup>

Governors were not the arrogant and ignorant men, bent on abusing their privileges, that the *Medical Times & Gazette* claimed, but hospital administration was far from perfect.<sup>62</sup> The *BMJ* believed that governors managed the ordinary functions well, but their duty ended there and 'if any philanthropic individual suggests some plan for the benefit of the patients out of the ordinary course, he is put down as a visionary, and all but too often treated as a nuisance'.<sup>63</sup> It was believed that governors were too preoccupied with their own concerns to be 'acquainted with the affairs of the hospital'.<sup>64</sup> However, where many governors remained uninterested, a small number of men devoted their time to the hospital, ensuring that the management was controlled not by the whole body, but by a select group. Under such a system, which was open to accusations of corruption, administrative continuity was assured. Issues were dealt with as they arose and there was little forethought or planning, but a certain institutional inertia existed as

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<sup>59</sup> *Lancet*, 2 (1869), 615.

<sup>60</sup> Cited in *BMJ*, 2 (1869), 592-3; 563.

<sup>61</sup> SBH Archive, Governors' Minutes, Ha/1/23.

<sup>62</sup> *Medical Times & Gazette*, 1 (1874), 210.

<sup>63</sup> *BMJ*, 1 (1857), 302-3.

<sup>64</sup> *City Press*, 6 November 1869.

governors were inclined to conservatism and were reluctant to offend subscribers. An interest in reform would be expressed, often to placate the Sunday Fund or the public, but they were disinclined to commit themselves. Medical developments tended to be the exception, especially at the German Hospital and the teaching hospitals where governors were keen to be at the forefront of medical advance and were pressurised into adopting new procedures by their medical staff. Extensive programmes of reform were delayed and governors strenuously resisted external pressure and criticism: their first reaction was to defend the hospital rather than change it. Reform, however, could not be avoided. Governors kept a careful note of developments in other institutions to prevent themselves from being isolated and when reform was linked to financial considerations, they were quicker to modify their opposition. The result was an administration that reacted to situations and responded in the face of change to keep the hospital running.

The governors' financial management was a constant source of attack. Given the London hospitals' permanent financial anxiety from the 1860s onwards this is not surprising. The endowed hospitals were censured for their extravagance, and hospitals were criticised for their fundraising activities and insolvency. The *Lancet* felt that finance committees were ineffectual and ill-equipped to manage the hospitals' economic affairs.<sup>65</sup> At University College Hospital only fifteen minutes were allocated at meetings in the 1860s to discuss the accounts despite the hospital's precarious financial position.<sup>66</sup> The Charity Commission was appalled at St.Bartholomew's accounting procedures, but it was a criticism that could be widely applied.<sup>67</sup> Critics believed that the governors' control of the hospitals' resources was inefficient, but they offered few alternatives other than the uniform system of accounts advocated by Burdett and the Sunday Fund.

Finance and fundraising dominated the work of the hospitals' management committees. Governors claimed complete authority over financial concerns: passing votes of thanks for all charitable contributions, negotiating loans, selling stock and land, and approving investments and mortgages. Public appeals were carefully planned and fundraising was discussed in detail. They controlled every aspect of the hospital's finance

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<sup>65</sup> *Lancet*, 1 (1883), 794.

<sup>66</sup> UCH Archive, General Committee, A1/2/2.

<sup>67</sup> SBH Archive, Charity Commission Letters, FD/7/5/2.

and no money could be spent without their approval. Doctors made suggestions for expenditure and were asked for their opinion on the advisability of certain items of expenditure, but they were rarely consulted over financial decisions. The reasons behind these decisions and the nature of the hospitals' finances were not discussed. Fundraising rather than expenditure aroused the most interest. The types of resources available and the reasons why new sources of funding were pursued have already been discussed, as have individual hospitals' financial concerns and their preferred system of funding. The resulting picture is a mixed one. Some institutions like the German Hospital and the Hospital for Sick Children marshalled their resources with care, investing surplus income, others like University College Hospital and Guy's had a more frivolous attitude, while the London responded as best it could to the pressures it experienced. The financial management of the hospital, however, was rarely linked to a predetermined strategy. Governors controlled spending, but there was no obvious favouritism in its allocation. Expenditure was not treated at a ward or even department level, and no effort was made to use the hospitals' accounts as a management tool to direct spending or to control expenditure. Instead finance was seen in the context of the institution's overall spending, a view that encouraged a preoccupation with the problems of finance and debt.

A study of the London hospitals' finances suggests that governors spent money when it was available, unless they were dealing with building, and pursued economies when it was not. Equally governors invested any surplus they had and then drew on it in times of need. Hospitals remained governed by their resources and this was the main influence on their management. Perhaps the only strategy that can be detected is the need to keep the hospital open and to match, as best as possible, income to expenditure. This created an overriding need for more funds. Hospitals' finances were not badly managed, but they were managed in a way that created a permanent anxiety for funds and resulted in periodic crises that required heroic feats of fundraising. Governors tried to administer resources as best they could, but it was not always possible to control the pressures that were exerted on the hospital. Given the nature of voluntarism with its amateur ethic and distrust of professionalism and bureaucracy, perhaps this was the best that could be hoped for. Reform occurred gradually and governors responded to problems as they emerged. If the hospital was not a dynamic institution, it was at least flexible, adapting within the

constraints of voluntarism and providing the institutional structure needed to dispense increasingly sophisticated medical relief.

## 5. WHO GOVERNED WHOM? THE SOCIAL ORIGINS OF THE GOVERNORS AND PATIENTS

The dominance of voluntarism in the hospitals' management and the slow pace of professionalisation ensured that by 1900 it was still philanthropists who dominated the hospitals' administration. This raises important questions about the social composition of these managing bodies: who managed the hospital?

The social origins of philanthropists, according to Prochaska, are '...usually difficult to determine'.<sup>68</sup> For all this, historians have tentatively agreed that most subscribers were middle class, a view confirmed by Marland's detailed analysis of the subscription lists of the medical charities in Wakefield and Huddersfield.<sup>69</sup> In London the structure of the economy strengthened this trend and metropolitan hospitals relied on middle-class support. According to the *Hospital's* pessimistic assessment in 1891, only 17% of the population contributed to a hospital.<sup>70</sup> Even fewer gave their time and it was from these philanthropists that the hospitals' governors were drawn. Who were they? Governors can be divided into three groups: those who gave sufficient money to become a governor but took no role in the hospitals' management, those who infrequently attended meetings, and those who formed the mainstay of the administration. It is this last group that needs analysis, as it was they who governed the hospital.

Women, according to Prochaska, were increasing their role in charitable associations, but in the London hospitals they played a marginal role in the administration.<sup>71</sup> It was not until 1887 that women were allowed to attend the Sunday Fund's meetings and Sir Edmund Currie's motion to admit women to the House

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<sup>68</sup> F.K.Prochaska, *Women and Philanthropy in Nineteenth Century England* (Oxford, 1980), 41.

<sup>69</sup> Marland, *Medicine and Society*, 117-22.

<sup>70</sup> *Hospital*, 28 February 1891, 320.

<sup>71</sup> Prochaska, *Women and Philanthropy*.

Committee of the London in 1893 was firmly rejected.<sup>72</sup> Women were excluded from the hospitals' main managing committees and Jordan, in her study of charity in Belfast, sees a similar male-dominated charity administration at a city level.<sup>73</sup> Women in hospitals were limited to fundraising activities, which governors believed provided a 'respectable' outlet for their energies and did not involve women in the more business oriented management of the hospital which was their sphere. For many women even a limited fundraising role, at which they were highly successful and proved dedicated campaigners for the hospital, must have been an outlet for boredom and a chance to play an active role outside the home.<sup>74</sup> This is seen in women's prominent position in organising bazaars. University College Hospital's 1886 bazaar was almost entirely organised by the wives of the hospital's governors, and Lady Goldsmid, the wife of the hospital's chairman, held a similarly important role within the bazaar committee.<sup>75</sup> Of the seven women on the German Hospital's Ladies Committee, only two were not connected by marriage to the main governing body.<sup>76</sup> Women achieved some influence as matrons and Lady superintendents over the hospitals' domestic and nursing arrangements, but the administrative environment remained predominantly male.

'Hospital committees', the *Charity Record & Philanthropic News* felt, 'are composed of gentlemen who have a special regard for the charities with which they are associated, who give freely both their money, and what is often of more value, their time'.<sup>77</sup> These two aspects, 'money' and 'time', were crucial in determining the social origins of the managing elite. The financial qualification for a governor, and the expectation that an active governor would be the first to help the hospital in times of hardship, ensured a certain social homogeneity. Only the affluent could afford to make

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<sup>72</sup> LH Archive, House Committee, A/5/45; *Hospital*, 17 December 1887, 200.

<sup>73</sup> A.Jordan, *Who Cares? Charity in Victorian And Edwardian Belfast* (Belfast, 1994), 199-206.

<sup>74</sup> F.K.Prochaska, 'Charity Bazaars in Nineteenth Century England', *Journal of British Studies*, 16 (1976-77), 84.

<sup>75</sup> UCH Archive, Subcommittee Minutes, A1/5/1.

<sup>76</sup> GH Archive, Bazaar Committee Minutes, Ha/68/2/1.

<sup>77</sup> *Charity Record & Philanthropic News*, 17 (1897), 75.



such a financial commitment. The second criteria, the element of 'time', further defined the governors' social class. In 1838 Lord Stanhope noted that only men of leisure could conveniently hold posts and his opinion reflected a social reality.<sup>78</sup> To hold an active position, governors had to devote time to the hospitals' affairs and attend monthly meetings. Membership of more than one committee or an active role as a House Visitor required weekly visits, while treasurers and chairmen attended almost daily. Where the middle classes were the predominant contributors, only the leisured and the wealthy could afford to dedicate this much time. Trainor's analysis of the leadership of philanthropic societies in West Bromwich and Dudley and Garrard's work on Bolton, Rochdale and Salford confirms this view.<sup>79</sup> Active governors were therefore invariably men of wealth, repute and social standing, and often important philanthropists who did not just limit their activities to medical charity.

The *Hospital* observed in 1892 that the most 'active' governors were men largely engaged in 'business' and Jordan notes that business connections were characteristic of charity in Victorian Belfast.<sup>80</sup> 'Business' interests dominated hospital management (see table 5.2), representing 49.7% of active governors, who largely owned or managed prominent, successful and wealthy companies or banks. Governors from London's leading banking and financial companies provided the main background for governors, brewing, printing, and publishing represented a significant proportion. To the governors involved in the City must be added 14.1% of those who came from largely professional backgrounds and of this group the medical profession formed the largest section. Governors with independent means, and clergy were also prominent, while those with aristocratic backgrounds played a marginal role and were not as significant as the 'landed-

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<sup>78</sup> B.Harrison, 'Philanthropy and the Victorians', *Victorian Studies*, 9 (1966), 359.

<sup>79</sup> R.H.Trainor, *Black Country Elites: The Exercise of Authority in an Industrialised Area* (Oxford, 1993); Garrard, *Leadership and Power in Victorian Industrial Towns*, 13-37.

<sup>80</sup> *Hospital*, 2 January 1892, 161; Jordan, *Who Cares?*, 201.

Table 5.1: Social Composition of Governors in West Bromwich and Dudley 1867-1900 (per cent).

	Upper Class & Upper Middle	Middle Class	Professional/ Commerce	Lower- Middle Class	Middle Class (unspecified)	Working Class	Unknown
Hospital	27	18	43	3	2	7	(6)

Source: Trainor, *Black Country Elites*, 400-1.

Table 5.2: Social Composition of Active Governors 1850-1898.

	Guy's	London Hospital	University College Hospital	Hospital for Sick Children	Royal Chest Hospital	German Hospital	Total (%)
Aristocracy	2	0	0	2	2	0	3.7
Independent means	2	2	6	1	1	2	8.6
M.P.s	2	0	0	0	1	0	1.8
Banking	7	3	2	4	1	1	11.0
Finance/Commerce	9	4	4	5	10	5	22.2
Manufacturing	1	2	0	1	6	1	6.8
Printing/Publishing	2	0	0	3	1	1	4.3
Brewing	1	8	0	0	0	0	5.5
Professional	0	2	3	10	6	2	14.1
Clergy	0	3	0	2	4	1	6.1
Military	0	2	0	1	0	0	1.8
Working Class	0	0	0	0	0	0	0.0
Unknown	7	1	0	5	4	6	14.1

Source: Guy's Archive, A96-99; Annual Reports 1850-1898, *Times*, *Dictionary of National Biography*, *Post Office Directory*, 1850-1899.

-classes', Roy Porter identified in the eighteenth-century infirmaries.<sup>81</sup> Hospital administration reflected society's inequalities of wealth and power, and mirrored the oligarchical managerial structure of other voluntary associations that were also dominated by these groups.<sup>82</sup> Within this framework each hospital had its own particular character, partly shaped by its location and nature. The German Hospital was managed by German émigrés; the London by those with brewing connections, reflecting a major area of employment in Whitechapel, and in Cardiff the infirmary received a large amount of its support from the dock interests.<sup>83</sup> No two hospitals were managed by the same occupational groups, a factor that reflected their location in London and the high degree of localism in London, but they were managed by men of similar commercial and business experience and wealth.

However, the Royal Chest Hospital does not entirely match the class character of the other hospitals studied. Here fewer governors came from the upper-middle class. Instead they had a more middle-class status and were linked to businesses trading on City Road or near the hospital. This difference can perhaps be accounted for by the hospital's character and its importance to the areas of employment that were susceptible to diseases of the chest, and because long-standing chest hospitals like the Brompton attracted the higher social groups interested in chest diseases.

The smallness of the philanthropic world ensured that close links developed between governors. Family connections provided an important tie. Hospitals did not become the personal fiefs of leading families, but the involvement of one member of the family often encouraged others to participate. Lushington came from a legal and political background, but his dedication to Guy's was due to his father's connection to the hospital from 1819 until his death in 1873.<sup>84</sup> At University College Hospital the Goldsmid family

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<sup>81</sup> R.Porter, 'The Gift Relations: Philanthropy and Provincial Hospitals in Eighteenth-Century England' in L.Granshaw & R.Porter (eds.), *The Hospital in History* (1989).

<sup>82</sup> R.J.Morris, 'Clubs, Societies and Associations' in F.M.L.Thompson (ed.), *The Cambridge Social History of Britain 1750-1950*, 3 (1993), 413.

<sup>83</sup> N.Evans, 'Urbanisation, Elite Attitudes and Philanthropy: Cardiff 1850-1914', *International Review of Social History*, 27 (1982), 297.

<sup>84</sup> J.Moore, *A Zeal for Responsibility* (1988), 54.

was important in the hospital's foundation and early management: Sir Isaac Goldsmid had been chairman from 1833 to 1855 and was succeeded by his son, Francis Goldsmid, who held the post until 1867.<sup>85</sup> Business connections emphasised these links. The East End's major brewing families were active in the London's management. With many governors involved in finance or in the Bank of England as directors, association through work was reflected in participation in hospital management. At the Royal Chest Hospital the involvement of Edward Sheppard and James Esdaile, both timber merchants, took this to an extreme. Their common business interests and the proximity of their timber yards encouraged their mutual interest in the hospital. Social connections emphasised the smallness of the philanthropic world. Many of the founders of the Hospital for Sick Children were known to each other personally.<sup>86</sup> Guy's practice of nomination ensured that governors came from a small social and evangelical group, with links strengthened between such governors as Philip Cazenove, Henry Hucks Gibbs and Money Wigram by their common membership of the Society of Nobody's Friends. In effect charity had a small managerial elite.

Working-class governors were not entirely excluded. Workers' contributions formed a significant component in the income of the Poplar Hospital, but their contribution to the hospital's management was relatively small. Working-class governors rarely made up 10% of the governing body.<sup>87</sup> At least until the late-Victorian period the poor 'were excluded from involvement in the government...' of the London and provincial hospitals.<sup>88</sup> Medical charity, and charity in general, seemed hostile to working-class participation in its management.

It was the Saturday Fund that took up the campaign for working-class governors.<sup>89</sup> The Fund aimed to raise the level of working-class support for the hospitals and as a *quid*

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<sup>85</sup> UCH 1909 Annual Report.

<sup>86</sup> J.Kosky, *Mutual Friends* (1989), 14; 117-128.

<sup>87</sup> N.Barnes, 'The Dockers' Hospital' (Unpublished BSc Dissertation, University of London, Wellcome Institute Library, 1993).

<sup>88</sup> Marland, *Medicine and Society*, 145.

<sup>89</sup> For the working of the Saturday Fund and its financial contribution to the London hospitals see pages 100-7.

*pro quo* for support it demanded that hospitals should issue it with subscribers' privileges and appoint working-class representatives. The Fund was merely playing on the traditional right of contributors to influence management and pushed for representation to increase its own support, but ironically the Fund's own administration contained few working-class representatives.<sup>90</sup> In this the Fund resembled the Bible societies which remained fundamentally middle class, but locally reflected the character of the community.<sup>91</sup> The Saturday Fund was not entirely a part of the growth of working-class cultural and leisure associations that developed from the mid-nineteenth century onwards, though it acknowledged that working-class had an important role to play in charity.<sup>92</sup> In its aims it partly reflected the mutual aid societies by offering its supporters the possibility of a return on their support in times of sickness through admission to a hospital. However, the Fund wanted to tap the assets of the working classes and was an organisation for them rather than of them.<sup>93</sup> The dominance of its middle-class leadership ensured that it adopted the vocabulary of limited working-class representation for the respectable and thrifty, but refused to extend this beyond these groups.

Robert Frewer, the Fund's secretary, tried to project the image that hospitals welcomed the movement, but governors were reluctant to agree to its conditions.<sup>94</sup> The *Medical Times & Gazette* feared that the Fund would herald an influx of working-class representatives, but its anxiety proved unfounded.<sup>95</sup> Governors were willing to give the Saturday Fund letters (though the exact number was often argued over), but they felt that the Fund's representatives were merely trustees of the money and not subscribers, and

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<sup>90</sup> H.C.Burdett, *Hospital Sunday and Hospital Saturday* (1884), 24.

<sup>91</sup> F.K..Prochaska, 'Philanthropy' in F.M.L.Thompson (ed.), *Cambridge Social History of Britain 1750-1950*, 3 (1993), 368.

<sup>92</sup> See S.Yeo, *Religion and Voluntary Organisations in Crisis* (1976), 185-235.

<sup>93</sup> See Morris, 'Clubs, Societies and Associations', 416-19 for the growth of working-class associations.

<sup>94</sup> *Charity Record & Philanthropic News*, 2 (1882), 36.

<sup>95</sup> *Medical Times & Gazette*, 1 (1874), 320.

therefore not entitled to be involved in the hospitals' management.<sup>96</sup> Henry Burdett, a supporter of working-class governors but not the Fund, felt that its proposals appointed men who were 'unknown' to the rest of the subscribers.<sup>97</sup> While the medical press attacked the Fund, many governors resisted its incursions on their exclusive government. When the Fund passed a resolution in January 1882 to 'appoint a governor to a hospital receiving not less than £50', eleven of the general hospitals, led by Colonel Haygarth of St. George's, protested. In response the Fund withheld the annual grant to University College Hospital, St. George's and the West London Hospital. The Fund's firm stance was eroded by the unpopularity of its action and the grants were paid in February.<sup>98</sup> Some, however, did give way. In 1879 the Hospital for Sick Children agreed to appoint a representative of the Saturday Fund as a governor, but stated that he would only have access to the general court and not the management committees.<sup>99</sup> Although the Fund had secured a point of principle, the governors ensured that it had no undue influence. In contrast, the German Hospital and the London succumbed to the Fund's economic blackmail.<sup>100</sup> The result, however, did not have a dramatic impact on the social composition of the hospitals' management.

The Saturday Fund was not the only body pressuring London's hospitals to appoint working-class governors. Members of Toynbee Hall, particularly Walter Pye, advocated working-class representation as part of the settlement movement's aim to promote community integration. Others writers concerned with the apparent breakdown in social harmony propounded similar views. However, the practical efforts made by workers' associations to secure representation were more effective.<sup>101</sup> At the Royal Chest Hospital several bids were made in the 1890s to appoint working-class governors. The first attempt was made in 1890 by an organised effort by local workmen, but it was firmly

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<sup>96</sup> *Charity Record & Philanthropic News*, 2 (1882), 120.

<sup>97</sup> *Times*, 7 November 1883, 12.

<sup>98</sup> *Lancet*, 1 (1882), 154.

<sup>99</sup> GOS Archive, Committee of Management, GOS/1/2/16.

<sup>100</sup> GH Archive, Hospital Committee, A/2/7; LH Archive, House Committee, A/5/40.

<sup>101</sup> *BMJ*, 1 (1886), 837.

resisted.<sup>102</sup> Progress was made in 1893. Bartlett, the appointed representative of several local collection schemes, approached the hospital with the suggestion that six of his nominees should replace six existing governors. He claimed that these organisations had a right to participate to ensure that their contributions were used wisely. Stephen Olding, the hospital's chairman, saw this as 'revolutionary' and was shocked by Bartlett's effrontery. The *Charity Record & Philanthropic News* recognised the support that local workmen gave to the hospital, but it could not justify Bartlett's action and warned of a 'mercenary spirit'.<sup>103</sup> To limit the damage, Olding proposed a compromise and agreed to elect three working-class governors. The Royal Chest Hospital's reluctant moves were symptomatic of a change in attitude. From the 1890s onwards a more favourable stance was adopted and journals gradually became sympathetic to the idea of working-class governors, but there was no increase in their appointment. Governors remained a wealthy and exclusive group, and even by the end of the century their social composition had not been greatly altered.

Who did this governing elite manage the hospital for? Hospitals had been founded to treat the deserving poor, a category of patient that was hard to define and often proved elusive. Governors had a duty to nominate a certain type of patient and this was often defined in the hospital's rules. Governors hoped to avoid the admission of children, pregnant women, fever, and chronic cases, but where this was not always possible, especially in teaching hospitals where the need for clinical material was often paramount, they retained, individually or collectively, nominal influence over admissions throughout the period.<sup>104</sup> Even at the Royal Chest Hospital, where from 1850 the medical staff were given the right 'to admit, as in- or outpatients, such Persons as they deemed fit objects of this Charity', all patients in theory had to be 'properly recommended' by a subscriber.<sup>105</sup> The right to admit patients under the 'letter' system developed with the growth of the metropolitan hospitals; such was its success that it was adopted throughout

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<sup>102</sup> *Hospital*, 15 March 1890, 382.

<sup>103</sup> *Charity Record & Philanthropic News*, 13 (1893), 148.

<sup>104</sup> See J. Woodward, *To Do the Sick No Harm* (1974) for hospital admissions policies and the type of patients theoretically excluded.

<sup>105</sup> RCH Archive, House & Finance Committee, A1/3.

the country.<sup>106</sup> Procedures varied between hospitals, but the aim remained the same. Essentially it was a scheme of incentives to encourage support, with each letter carrying the right to admit a patient and in theory guaranteeing treatment or at least the attention of a doctor. Under the scheme it was the philanthropist who decided which patients would attend the hospital and which cases should be admitted. Patients therefore made strenuous efforts to acquire letters, though at University College Hospital this process was eased as a list of subscribers was kept in the waiting room for patients to consult.<sup>107</sup>

Though governors' letters remained until the twentieth century, they became less important in admissions. Waterlow commented in 1890 that 'practically it makes no difference whether the person comes with a letter or not, excepting that the letter is accepted as some evidence that the patient is a person who ought to be treated; but really the eligibility to admission is the degree of suffering'.<sup>108</sup> At the London subscribers' recommendations fell from 46% of cases treated in 1855 to 9% in 1898, a fall symptomatic of a general decline. By 1910 recommendations were rarely required. Under these conditions doctors requested that letters be abandoned as it appeared unethical to treat a case simply because it was recommended by a subscriber with no medical knowledge. They were joined by hospital reformers concerned with the London hospitals' financial position and they complained that contribution did not match the cost of treatment. Changes were made which reflected the doctors' increased control over admissions. At the Hospital for Sick Children governors' letters retained their precedence, but the medical staff had the final veto on suitability, inverting the medical philanthropic relationship.<sup>109</sup> No London hospital was prepared to abandon recommendations because it was felt that they were essential in retaining philanthropic support.

All hospitals kept detailed inpatient records, but no records were kept for the mass of outpatients that passed through the hospitals' doors. David Glass observed in 1940 that

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<sup>106</sup> H.Hart, 'Some Notes on the Sponsoring of Patients for Hospital Treatment under the Voluntary System', *Medical History*, 24 (1980), 447.

<sup>107</sup> UCH Archive, UNOF/2/3 (1).

<sup>108</sup> SC of the House of Lords on Metropolitan Hospitals, 2nd Report, *PP* 1890/1 XIII, 164.

<sup>109</sup> GOS Archive, Board of Governors, GOS/1/6/1.



‘a very large arbitrary element is involved in grouping occupations... into social classes’.<sup>110</sup> While it is undoubtedly useful to provide data on separate occupations, the information collected would be too cumbersome. Assumptions have to be made so that a general impression of social structure of admissions can be produced. Banks’s work on the occupational structure of the nineteenth century provides a useful guide. He believed that the categories used in the 1911 Census are the most reliable guide because they reflect the element of superiority-inferiority implicit in a class structure.<sup>111</sup>

Table 5.3: Banks’s Classification Scheme

Class	Classification	Occupations (sample)
I	Professional Occupations	Clergy, Clerks, law Medicine, Property Owning, Public Service, Teaching etc.
II	Intermediate Occupations	Butchers, Bakers, Drapers, Grocers, Haberdashers, Ironmongers, Pawnbrokers, Publishers, Pensioners, Shopkeepers, etc.
III	Skilled Occupations	Bricklaying, Carpenters, Domestic (indoor), Footwear Manufacturers, Gunsmiths, Hairdressers, Instruments, Printing, Plasters, Plumbers, Seaman, Tailors, Waiters, Wheelwrights etc.
IV	Semi- Skilled Occupations	Agriculture, Brewers, Coopers, Domestic (outdoor), Fishermen, Furriers, Laundry Workers, Machinists, Millers, Postmen, Sculptors, Tanners, Turners, Warehousemen etc.
V	Unskilled Occupations	Bargemen, Cabmen, Costermonger, Labourers, Mining, Porters, Sugar Refiners etc.

Source: Banks, ‘Social Structure of the Nineteenth Century’, 203-23.

Hospital records do not feature the same degree of detail as censuses, but they suffer from similar problems of nomenclature, which shifted to match economic development.

<sup>110</sup> Cited in J.A.Banks, ‘The Social Structure of the Nineteenth Century as seen through Census’ in R.Lawton (ed.), *The Census and Social Structure* (1978), 196.

<sup>111</sup> Banks, ‘Social Structure of the Nineteenth Century’, 190-195.

Categories were assigned on the opinion of the admitting officer, medical registrars were not appointed until later in the period. Gaps exist where those compiling the records did not have time to record the occupation or the patient was in no fit state to answer the question. Mostly it was in response to patients' replies that occupations were listed, giving some interesting professions. Distinctions were infrequently made between a skilled or a common labourer, an agricultural labourer or a dock labourer. The impression given is that if a patient told the admissions officer that he/she worked with jelly then he/she was listed as a 'jelly worker'. As a result only a general impression can be gained - it was after all a general impression that the Victorians relied on when they claimed that hospitals were abused by middle-class patients.

The social dimension of outpatient admissions is inevitably coloured by the contemporary debate over outpatient abuse. Victorians saw an influx of undeserving patients in the rapid expansion of the capital's outpatients' departments. James Pollock, writing to *The Times* in 1871, expressed a view that became common:

the social condition of a large number of those attending was observed to be far removed from poverty, and such as scarcely to permit their being regarded as legitimate objects of gratuitous relief. Persons provided with governors' orders, but belonging to the comfortable, and even occasionally to the richer classes, thus occupied the valuable time of a hard working medical attendant and interfered with the relief of the truly deserving... Some by an annual guinea subscription, become governors and nominate themselves as patients. Others give their orders indiscriminately to persons who may be their dependants, but who are well able to enumerate their medical attendants, and thus the large class of general practitioner is defrauded.<sup>112</sup>

The rhetoric of the debate concealed the medical profession's desires to regulate their working environment and address the problems that a large influx of patients brought. Philanthropists guided by the COS expressed concerns about the hospitals' pauperising influence and the waste of charitable resources; doctors echoed these concerns and complained about the damaging effect patient numbers had on hospital and private practice. Abuse was discerned as it was convenient to link an increase in admissions to

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<sup>112</sup> *Times*, 25 May 1871, 10.

an influx of undeserving patients, rather than admit that hospitals were increasingly serving a medical function that was at odds with their philanthropic origins. Abuse was seen to exist, and though solutions were suggested, the absence of a unanimous opinion and hostility from the hospitals, ensured that the solutions proposed in the 1870s were still being put forward in the 1890s.

It is difficult to learn the full extent of abuse and contemporaries themselves were divided. The *Hospital* noted in 1887 that ‘when we come to discuss how much abuse there is, there arises great differences of opinion’.<sup>113</sup> Surveys conflicted and the criteria for each assessment differed; most relied on impressionistic evidence in the absence of accurate hospital statistics. Few observers entirely dismissed abuse, though governors, in an attempt to avoid bad publicity, played down its extent. In 1897 the *Lancet* conducted its own investigation and sixty institutions were polled. Of the fourteen general hospitals asked, nine denied that any abuse occurred and those that acknowledged abuse noted that it was ‘very small indeed’.<sup>114</sup> The *Lancet* itself was not entirely convinced, retaining the view that abuse was widespread, a view that matched general opinion.

It seems improbable, given the hospitals’ poor but improving image, that there was a great or sudden influx of middle-class patients, but without records it is difficult to be certain. A more accurate view of the types of patients that hospitals treated can be gained from the inpatient records. After all, many inpatients were referred from the outpatients’ departments. The admission registers at Guy’s and the medical registrars’ reports at St.Bartholomew’s offer the clearest indication of the social background of patients admitted. Waterlow characterised St.Bartholomew’s as ‘the principal hospital in the centre of London; it draws a large number of patients from the East End, from Shoreditch, Curtain Road, and a large number of the accidents that befall persons employed in various manufacturing places...’.<sup>115</sup> None of these areas were considered as residential districts for the middle classes. In 1861 of the 5,565 cases admitted 59 were clerks. Against this 1,286 were engaged in service, 534 in labouring, 194 worked as carpenters, and 116 as

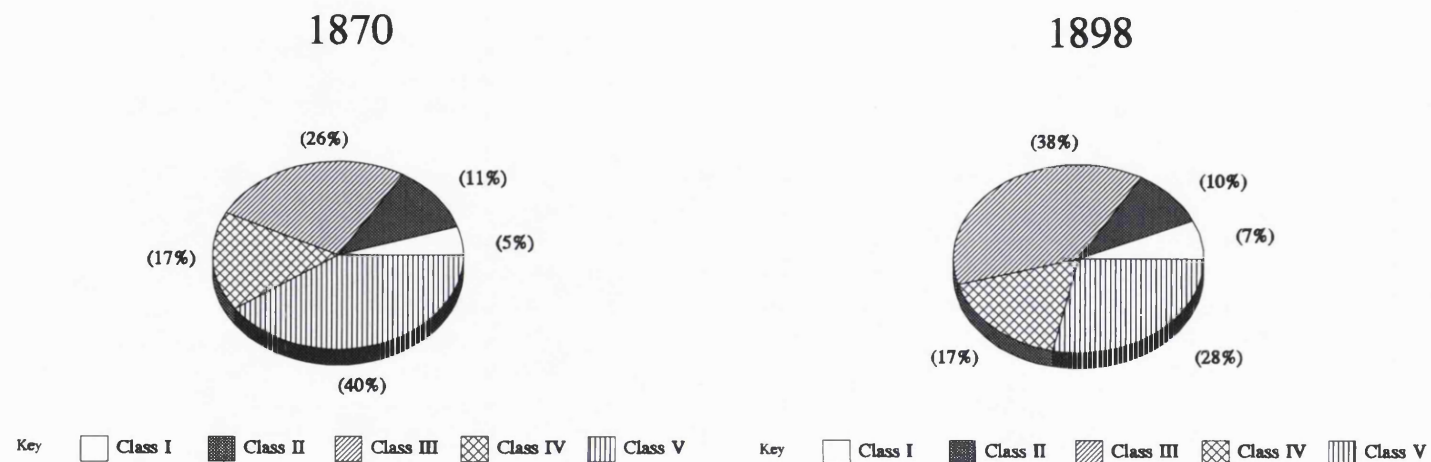
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<sup>113</sup> *Hospital*, 2 July 1887, 237.

<sup>114</sup> *Lancet*, 1 (1897), 1657.

<sup>115</sup> SC on Metropolitan Hospitals, 1st Report, 171.

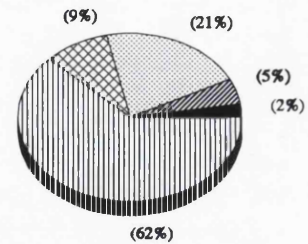
## St. Bartholomew's Hospital: Patient Admissions (male)



Source: SBH Archive, Tables of Surgical & Medical Registrars, MR/9/62; MR/9/84.

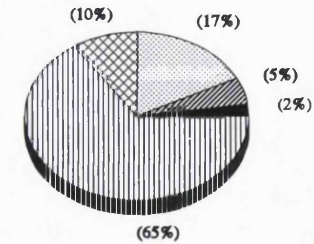
# Guy's Hospital: Patient Admissions

1855



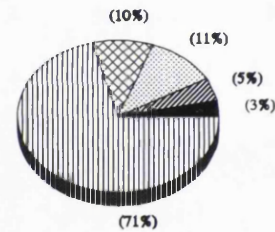
Key ■ Class I ▨ Class II ▩ Class III ▤ Class IV ▦ Class V

1875



Key ■ Class I ▨ Class II ▩ Class III ▤ Class IV ▦ Class V

1890



Key ■ Class I ▨ Class II ▩ Class III ▤ Class IV ▦ Class V

Source: Guy's Archive, Patient Records, B2/1,5; B3/1,7,12; B25/2.

shoemakers.<sup>116</sup> The pattern of occupations was more diverse by 1898, yet maintained its working-class character. It was not the middle class who made up the majority of cases; though their numbers increased, their proportion of admissions grew only slowly for St.Bartholomew's continued to draw its patients from the working classes. Guy's presents a similar pattern. It might be expected that the introduction of a paying system at Guy's in 1884 would have greatly affected admissions. Outpatient admissions fell dramatically, but there was no sudden change in the social composition of the patients treated. In 1855 only 35 clerks were admitted out of a total of 4,063 patients; by 1890 the number of clerks treated had risen to 83, mostly as surgical cases, but this was only a fraction of the 5,725 patients admitted. When this figure is considered as a proportion of the total number of patients admitted, the relative size of middle-class patients is lower than in 1855. The payment scheme may have helped legitimise the number of middle-class patients being treated, but it did little to transform the social character of admissions.

These findings are supported by admissions to the German Hospital. The German Hospital offers a useful comparison as it emulated the voluntary hospitals in its concern to treat 'deserving' cases, but its ethnic character ensured that its patients were primarily drawn from the disparate German community in London. Until the nineteenth century the movement of Germans into Britain had been on a relatively small scale.<sup>117</sup> Exact figures are not available until the 1861 Census when the German population was numbered at 28,644; by 1911 this had almost doubled to 53,324, a figure that excluded naturalised Germans.<sup>118</sup> With no firm residential area, the community was a heterogeneous collection of migrants and immigrants.<sup>119</sup> Drawn to Britain by economic and educational

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<sup>116</sup> SBH Archive, Statistical Tables of Medical & Surgical Registrars, MR/9/58.

<sup>117</sup> H.Kellenbenz, 'German Immigrants in London' in C.Holmes (ed.), *Immigrants and Minorities in British Society* (1978), 64-67.

<sup>118</sup> P.Panayi, 'Germans in Nineteenth Century Britain', *History Today* (1993), 48.

<sup>119</sup> Although German immigrants were not concentrated in any one locality, they mainly settled in three areas: East London, particularly Whitechapel and Stepney; West London in Westminster, St.Marylebone, Paddington, Kensington and St.Pancras; and North London, predominantly in Kentish Town, Camden and Islington where a German Church had existed since 1862: P.Panayi, *The Enemy in Our Midst: Germans in Great Britain during the First World War* (New York, 1991), 17-19.

opportunities and the host's traditional attitude of toleration, and pushed by persecution at home, over 50% of German immigrants lived in London so that Germany was '...by far the largest contributor to the foreign population of London'.<sup>120</sup> Panayi provides an assessment of the occupational structure of these Germans living in London:

Table 5.3: Occupational Structure of German Community in London (1911).

Occupation	1911	%
Schoolmasters, Teachers, Professionals, Lecturers	264	2.4
Domestic servants	1818	16.7
Clerks	1584	14.6
Seamen	257	2.4
Tailors	1297	11.9
Hairdressers, Wigmakers	1298	11.9
Butchers, Meat Salesmen	377	3.5
Bread, Biscuit, Cake etc Makers, Bakers, Confectioners	1826	16.7
Waiters	2161	19.8

Source: Panayi, *Enemy in Our Midst*, 22.

His figures conflict with xenophobic contemporary accounts that aimed to show that the German population was a threat.<sup>121</sup> Few Germans reached the very heights of British society and most remained within the working class. German clerks represented only 0.6% of the clerical labour force, but they attracted a disproportionate amount of attention

<sup>120</sup> See R.Ashton, *Little Germany: Exile and Asylum in Victorian England* (Oxford, 1986), for an account of the experiences of the German refugees who escaped to Britain following the 1848 revolution; P.Panayi, 'German Community' in N.Merriman (ed.), *The Peopling of London* (1993), 122; C.Booth, *Life and Labour of the People in London*, 3 (1902), 102.

<sup>121</sup> See A.Shadwell, 'The German Colony in London', *National Review*, 26 (1896), 807.

given the widespread opposition to them as an extension of late nineteenth-century Germanophobia.<sup>122</sup>

Admissions to the German Hospital reflected this occupational structure, but the admissions' returns are complicated by two factors. The paying sanatorium ensured that patients of a higher social class were admitted than at other voluntary institutions, while English patients were not totally excluded. Increasingly from the 1880s onwards subscribers used their position to suspend the regulations and admit non-German patients. Mr Allman was not unique in securing the treatment of his English shop assistant in February 1886. The excuse given was that the case was exceptional and that Allman was a generous benefactor.<sup>123</sup> The medical staff were similarly able to transfer non-German speaking patients from the outpatients' department on medical grounds.<sup>124</sup> These cases were always viewed as 'exceptional' and had to be specially sanctioned by the governors. However, German nationality and the ability to speak German remained the main criteria for admission.

At first glance it might appear that the number of middle-class patients admitted justified contemporary fears of outpatient abuse. However, the hospital's sanatorium admitted patients of a slightly higher class than the wards and charged them accordingly explaining why admissions from Class II and III were larger than at other hospitals. The gratuitous treatment of wealthy and aristocratic patients adds further complications. For example, Baron von Dedel, son of the former Netherlands Minister at the Court of St. James, was treated free of charge in 1881 after he had fallen on hard times, while Baron Munster insisted on paying the two guinea charge for a week's treatment in 1883, despite the governors' insistence that his treatment had been free.<sup>125</sup> However, the numerical significance of classes IV and V and the relative stability of classes II and III

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<sup>122</sup> G. Anderson, 'German Clerks in England; 1870-1914: Another Aspect of the Great Depression Debate' in K. Lunn (ed.), *Hosts, Immigrants and Minorities: Historical Response to Newcomers in British Society 1870-1914* (Folkstone, 1980), 203-217.

<sup>123</sup> GH Archive, Hospital Committee, A/2/8.

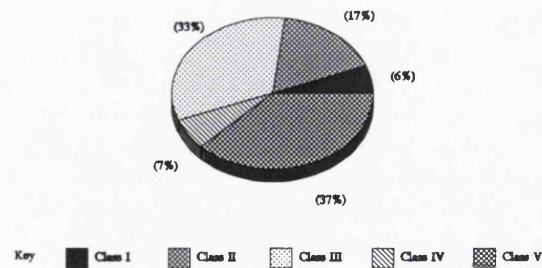
<sup>124</sup> For example in 1865 Dr Cartland and Dr Lichtenberg secured the admission of a non-German patient on the grounds that an operation was absolutely necessary: GH Archive, Hospital Committee, A/2/4.

<sup>125</sup> GH Archive, Hospital Committee, A/2/7.

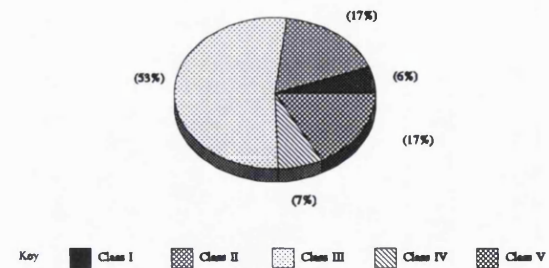


# German Hospital: Patient Admissions

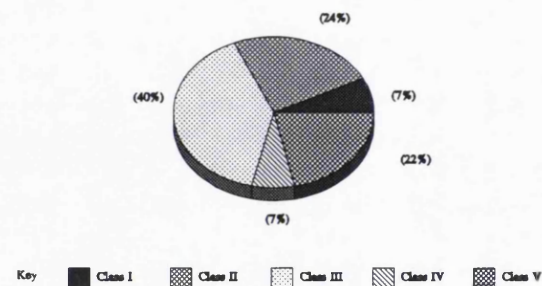
1855



1875



1893



Source: Annual Reports.

suggests that there was no sudden influx of middle-class patients. Of the 540 cases admitted in 1855, seven were clerks and only four could be considered professional. Against this there were 39 labourers and 134 engaged in sugar-baking; only six patients were considered to be 'without calling', reflecting an ambiguous social status.<sup>126</sup> By 1893, though the occupational structure had diversified, the essentially working-class orientation remained. Clerks represented 5% of admissions and though the number employed in professional occupations had increased to 30 this was only 3.4% of the total number of cases treated. Most remained within the working class. The number of sugar-bakers had fallen to fourteen cases, but the number of labourers had risen to 134, reflecting a change in the labour market for German immigrants.<sup>127</sup> No patient was admitted 'without calling'. Whether this reflects a conscious policy by the governors to exclude the undeserving or residuum in an attempt to limit the hospital to the deserving poor, or whether it indicates that the level of employment within the German community had increased, is uncertain. Governors constantly employed the rhetoric of undeserving and deserving poor, but it is doubtful if such a policy extended to the doctors admitting patients who were more concerned with medical criteria. The German Hospital, like St.Bartholomew's and Guy's, tended to treat patients who were within the working class and the governors felt that the patients they admitted were from the 'Humbler classes'.<sup>128</sup>

From additional circumstantial evidence, it can be assumed that the experiences of Guy's, St.Bartholomew's, and the German Hospital reflect the experiences of other institutions. Granshaw's work on St.Thomas's gives a further indication that there was no substantial change in admissions.<sup>129</sup> At the Hospital for Sick Children of the 74 cases listed in the 1863 Admissions Register where the father's occupation is stated, only two were clerks, one a servant.<sup>130</sup> Even during the COS's three month inquiry in the social background of the hospital's patients in 1875 only 1% of applicants were rejected because

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<sup>126</sup> German Hospital 1855 Annual Report.

<sup>127</sup> German Hospital 1893 Annual Report.

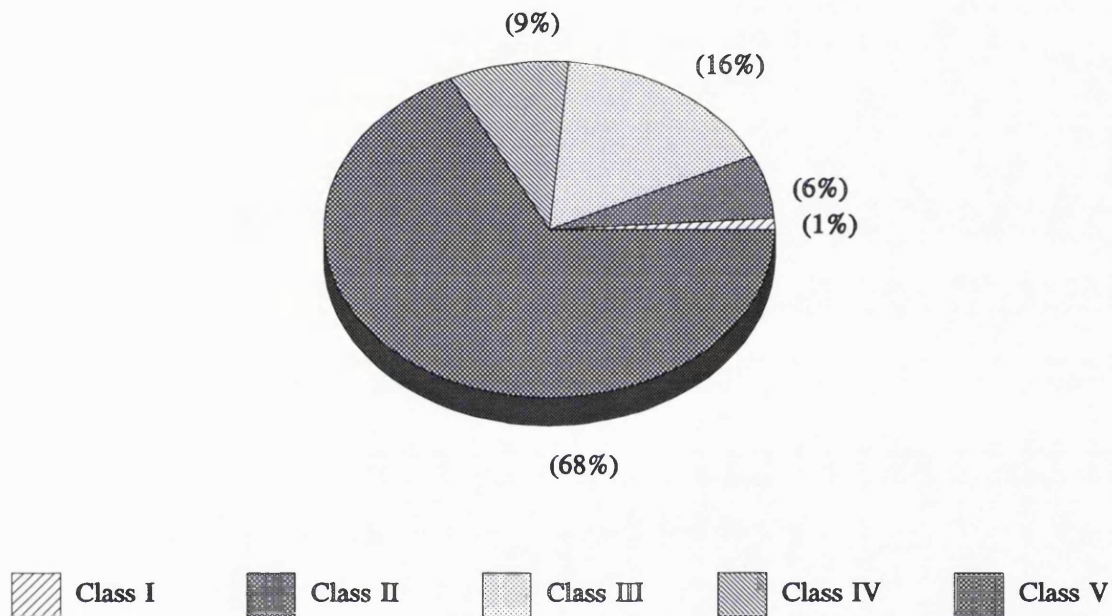
<sup>128</sup> German Hospital 1852 Annual Report.

<sup>129</sup> Granshaw, 'St Thomas's', 62-67.

<sup>130</sup> GOS Archive, Admissions Book, GOS/9/1/6.

of their earnings.<sup>131</sup> The London presents a similar picture. The hospital's own claims in 1854 that it treated 'sick and wounded seamen, manufacturers, labourers, women and children' are supported by an analysis of the social background of cases operated on between 1852 and 1862.<sup>132</sup>

Figure 5.4: London: Register of Operations (1852-1862)



Source: LH Archive, Register of Operations, M/3/74.

Steele, medical superintendent at Guy's, when investigating thirteen London hospitals in 1878, came to a similar conclusion. He found that where patients had been of some means they had generally already exhausted them in consulting a general practitioner, or were seeking the use of the hospitals' specialist departments for which they would be

<sup>131</sup>FWA, C/D52/1; GOS Archive, Medical Committee, GOS/1/5/6.

<sup>132</sup> London Hospital 1854 Annual Report.

unable to afford the consultant's fee.<sup>133</sup> Such groups, who had made an attempt at self-help, could be considered deserving. So sure were the governors of the Royal Chest Hospital that this was the case that they claimed in 1874 that all the cases treated were 'deserving'.<sup>134</sup> Though this was a careful piece of publicity it does point to the fact that many voluntary hospitals remained primarily for the treatment of the working class. Patients were admitted from all sections of society, even the notorious residuum, but as Steele noted 'although the hospitals are ostensibly founded for the benefit of the poor it is more the working class that we have to deal with, from the dock labourer up to the skilled mechanic'.<sup>135</sup>

Given the hospitals slow improvement in their image this is hardly surprising. Whether these working-class patients were legitimate cases for charity must remain uncertain. The working class had few alternatives to hospital treatment outside the Poor Law and the cost of private consultation with a specialist made it prohibitive. 'To say that we do not relieve a certain percentage who are not deserving of it', notes the treasurer of St.Bartholomew's, 'would be saying too much'.<sup>136</sup> It was an axiom that could be widely applied. Several factors conspired to alter the class basis of hospital admissions. The very existence of an outpatients' department where accidents were received ensured that hospitals could never be entirely for the working class. In the London's case this was magnified as the pressure of numbers ensured that only accident and emergency cases were admitted. Specialist departments attracted those who could not afford consultants' fees, a fact that extended to most of the specialist hospitals. This served to modify the hospitals' working-class character. Patients from the middle class did therefore gradually increase as a reflection of the hospitals' modified image, but this was not enough to alter the hospitals' character.

The transformation of the hospital to a medical institution did not alter the voluntary rationale behind the hospitals' management or revolutionise the types of patients being

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<sup>133</sup> J.Steele, *Summary of Information Relative to the Working of the Out-patient Departments in Thirteen London Hospitals* (1878).

<sup>134</sup> RCH 1974 Annual Report.

<sup>135</sup> SC on Metropolitan Hospitals, 1st Report, 34.

<sup>136</sup> SC on Metropolitan Hospitals, 1st Report, 172.

treated. Hospitals remained voluntary organisations administered by a small philanthropic elite, treating essentially working-class patients, though admissions greatly increased as the perceptions of the hospital and medical science changed. Few suggested a comprehensive alternative to the voluntary provision of healthcare, even though more patients were treated by the Poor-law infirmaries. This would suggest a static model. However, though voluntarism remained the administrative rationale, the philanthropists' claim to authority was challenged. A diversification of income did not affect the philanthropists' supremacy, but the rise of the medical profession who claimed authority through knowledge rather than through contributions did. The extent to which the medical profession was able to extend its power within the hospital provides the subject of the next chapter.

## Striving for Influence - Lay v. Medical Control

The voluntary ethic permeated every aspect of the London hospitals' services and management. Governors established their administrative credentials through their voluntary financial commitment, and for all but the most junior posts doctors donated their services free of charge. However, the medical profession's service was not as 'altruistic' as that of the governors. Hospitals were only part of a system of institutional medical posts available to practitioners, but where an appointment at a provident dispensary or prison might bring much needed income for some doctors, a position at one of the London hospitals conferred an elite status.<sup>1</sup> In provincial towns the local medical elite were less dependent on hospital appointments for status, but for London, according to *The Times* in 1869, a

connection with a great hospital is an object of primary ambition to every London physician or surgeon. It gives professional status; it brings fees for tuition that are serviceable during the time of waiting for fame; it often leads to large and lucrative practices.<sup>2</sup>

Edmund Lushington justified the non-payment of appointments with the fact that doctors themselves 'felt it was a great advantage to belong to a hospital'.<sup>3</sup> One correspondent to the *Medical Times & Gazette* even suggested that doctors should pay anything up to £300 per annum for posts because of their commercial value.<sup>4</sup> Appointments were only gradually opened to competition and medical concerns were not initially prominent in the selection of candidates. The 1834 Select Committee on Medical Education pointed to a system of nepotism where appointments were regulated by a closed network of kinship

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<sup>1</sup> A. Digby, *Making a Medical Living: Doctors and Patients in the English Market for medicine 1720-1911* (Cambridge, 1994), 224-49

<sup>2</sup> *Times*, 30 January 1869, 4.

<sup>3</sup> *Charity Record & Philanthropic News*, 5 (1885), 116.

<sup>4</sup> *Medical Times & Gazette*, 1 (1864), 401.

and social connections.<sup>5</sup> Hospital doctors and governors favoured relatives and their students, excluding promising candidates sometimes in favour of men who lacked skill but had connections. Gradually the system changed with the development of the hospital's teaching functions and the decline of the apprenticeship system which removed students' link to individual members of staff. Nepotism, however, persisted though in a muted form, and the limited number of hospital posts, with only ten vacancies for a full surgeon at St.Bartholomew's between 1861 and 1890, ensured that competition remained intense.<sup>6</sup> Under these conditions it might be expected that doctors were prepared to put up with much. Struggling students and recent graduates worked long hours in overcrowded and insanitary outpatients' departments for a small honorarium and the possibility of a 'lucrative' permanent post. Anne Digby suggests that outside London doctors' grievances over their working conditions, their calls for remuneration, and their desires for medical 'autonomy' were overridden by the perceived benefits of being attached to a hospital.<sup>7</sup> However, in the London hospitals the issue of medical authority became increasingly important.

The voluntary relationship between governors, doctors and patients should not obscure the administrative changes that were taking place. Increasingly, the interests of the governors and those of the medical profession diverged, creating tension within the hospitals' management. Medical practitioners, at least in London, did not mirror the more assertive class of practitioner that Mary Fissell has identified in eighteenth-century Bristol.<sup>8</sup> Unlike Bristol, doctors in London had not begun to play a prominent role in hospital administration by the start of the nineteenth century. The nature of Bristol's society was more convivial to an extension of medical authority. Doctors could be part of the provincial social elite where a less marked social distinction existed between them and hospital governors. In London the governors' social importance and wealth clearly

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<sup>5</sup> SC of Medical Education, *PP* 1834 XIII, 98.

<sup>6</sup> M.J.Peterson, *Medical Professions in Mid-Victorian London* (Berkeley, 1978), 141-71; 162.

<sup>7</sup> Digby, *Making a Medical Living*, 125.

<sup>8</sup> M.E.Fissell, *Patients, Power and the Poor in Eighteenth Century Bristol* (Cambridge, 1991).

separated them from their medical staff who remained essentially a part of the new professional middle class. The reason might also lie in Fissell's definition of authority, as she places less emphasis on the doctors' leverage on policy. When the medical profession's influence in hospital administration is considered, it appears that even by the 1890s, doctors in the London hospitals remained in a subordinate position. However, as Peterson and Abel Smith have argued, from the mid-Victorian period doctors started to enter a managerial partnership with the hospitals' lay administrators.<sup>9</sup> This raises important questions about how this transition was possible when the medical profession had to compete with the governors' authority.

## 1. SOCIOLOGY, MEDICAL HISTORIANS AND DEBATES OVER PROFESSIONALISATION

The extension of medical authority is an aspect of the professionalisation of medicine; the two were inter-linked. Professionalisation has sparked a prolonged sociological controversy over what constitutes a 'profession' and how 'professionalisation' is achieved.<sup>10</sup> The 1950s saw a move to define professional status and a series of models were proposed that created a check-list progress to professionalisation. In the 1970s and 1980s a new trend emerged after Johnson's pioneering study.<sup>11</sup> Emphasis shifted from studying professionalisation as the development of a series of traits, to look at professionalisation as a mode of control and power. According to Johnson:

not only do "trait" approaches tend to incorporate the professionals' own definition of themselves in seemingly neutral categories, but the categories tend to be derived from the analysis of a very few professional bodies and include features of professional organisation and practice which found full expression only in Anglo-American culture at a particular time in the historical development of these professions.<sup>12</sup>

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<sup>9</sup> Peterson, *Medical Profession*, 187-8; B.Able Smith, *The Hospitals 1800-1948* (1964).

<sup>10</sup> See M.S.Larson, *Rise of Professionalism* (California, 1978); J.Jackson (ed.), *Professions and Professionalism* (Cambridge, 1970); or A.Witz, *Professions and Patriarchy* (1992).

<sup>11</sup> T.J.Johnson, *Professions and Power* (1972).

<sup>12</sup> Johnson, *Professions*, 26.



Johnson saw professionalisation in structural terms, treating it as an institutional means of controlling occupational activities. Other sociologists have adopted this view in what Witz describes as a neo-Weberian analysis.<sup>13</sup> In these interpretations power is internalised within the profession to create a system of occupational closure. According to Freidson, it is the 'special knowledge of the profession' which justifies their relation to society and degree of autonomy, with all professional groups claiming an exclusive body of knowledge.<sup>14</sup> He goes on to argue that knowledge can be equated with power and used to gain the right to control the working environment.<sup>15</sup> For Rueschemeyer, professions use this knowledge to strike a bargain with society in which they offer integrity and self-control in return for freedom from supervision.<sup>16</sup> However, their exercise of 'some degree of supervisory and policymaking authority', is restricted by the 'management's resource allocation decisions'.<sup>17</sup> Where does this leave the medical profession in the nineteenth century? Is it possible to fit the doctors working in the Victorian London hospitals into the model of an autonomous profession in control of its workplace?

Medicine was one of the old liberal professions, but unlike law and the church, it was associated with trade and remained the lesser of the three, a stepping-stone to more prestigious careers for latter generations. Doctors only slowly acquired a professional status and were quickly matched by the new emergent professions of architecture or accountancy.<sup>18</sup> The medical professions was part of Britain's rising professional society,

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<sup>13</sup> See F.Parkin, *Marxism and Class Theory* (1979); N.Parry & J.Parry, *Rise of the Medical Profession* (1976); G.Larkin, *Occupational Monopoly and Modern Medicine* (1983); Witz, *Professions*, 41.

<sup>14</sup> R.Dingwall & P.Lewis (eds.), *Sociology of the Professions* (1983), 50.

<sup>15</sup> E.Freidson, *Professional Powers: A Study of the Institutionalisation of Formal Knowledge* (1986); E.Freidson, *Professional Dominance: The Social Structure of Medical Care* (New York, 1970).

<sup>16</sup> D.Rueschemeyer, 'Professional Autonomy and the Social Control of Expertise' in Dingwall & Lewis (eds.), *Sociology of the Professions*, 41.

<sup>17</sup> Freidson, *Professional Powers*, 154.

<sup>18</sup> See A.M.Carr Saunders & R.A.Wilson, *The Professions* (Oxford, 1933) for a classic account, also T.Gourvish, 'The Rise of the Professions' in T.Gourvish & A.O'Day (eds.), *Later Victorian Britain*, (Basingstoke, 1988).

but opinions differ over the extent and timing of their professionalisation.<sup>19</sup> Holmes sees the years 1680 to 1730 as decisive, but this ascribes an undue importance to the eighteenth-century practitioner. Most other historians have turned their attention to the period after 1750. Gelfand and Ivan Waddington have adopted Jewson's sociological analysis in suggesting that professionalisation was located in the move from a 'client-dominated' practice in the eighteenth century, to a 'doctor-dominated' practice in the nineteenth.<sup>20</sup> Digby, however, argues that an economic dimension modified the doctor-patient relationship so that 'there is an even balance between the financial standing of the patient and the clinical expertise of the doctor'.<sup>21</sup> Others have adopted a more defined period of professionalisation. For Holloway 1830 to 1858 is the crucial period; by contrast, Peterson places the transformation between the 1858 Medical Act and the 1886 Medical Amendment Act.<sup>22</sup> A more recent view is that of Loudon who argues that by 1850 'the main structure of the present medical profession had been created'.<sup>23</sup> If the time scales conflict, it seems certain that by the 1850s the medical profession had started to emerge as a concerted, albeit, dual professional group split between the hospital elite and general practitioners.

Following Foucault's *Birth of the Clinic*, analysis has seen the hospital as the locus for a new relationship between the doctor and the patient in which a new bio-medical model of medicine emerged.<sup>24</sup> Hospitals, according to Jewson, based medicine on pathological lesions that were only accessible through medical knowledge, transferring the definition of disease from the patient to the doctor, allowing him to dominate their

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<sup>19</sup> H.Perkin, *Rise of Professional Society: England Since 1880* (Princeton, 1989).

<sup>20</sup> T.Gelfand, 'Decline of the Ordinary Practitioner and the Rise of the Modern Medical Profession' in S.Statum & D.E.Larson (eds.), *Doctors, Patients and Society: Power and Authority in Medical Care* (Ontario, 1981); I.Waddington, *Medical Profession in the Industrial Revolution* (Dublin, 1984).

<sup>21</sup> Digby, *Making a Medical Living*, 6.

<sup>22</sup> S.W.F.Holloway, 'Medical Education in England 1830-1858', *History*, 49 (1964); ; Peterson, *Medical Profession*.

<sup>23</sup> I.Loudon, *Medical Care and the General Practitioner 1750-1850* (Oxford, 1986), 3.

<sup>24</sup> M.Foucault, *Birth of the Clinic* (1975).

relationship.<sup>25</sup> A recent collection of essays edited by Porter and Jones has provided a detailed analysis of Foucault's ideas. However, while the contributors have meticulously analysed Foucault's approach and the power of medicine, discussion remains located within the hospitals' medical environment.<sup>26</sup> Where doctors had power over their patients, as Armstrong suggests in a form of 'medical surveillance', could they also use the same body of knowledge in their relationship with the governors?<sup>27</sup>

## 2. MEDICINE AND MEDICAL SCIENCE

Victorian medicine was undergoing a period of change and advance, but it was not an 'age of miracles'.<sup>28</sup> Leeches, bleeding and amputation provided the mainstays of an unregistered medical profession in 1850, where to undergo surgery was 'sure to skirt the borders of death' and prescriptions often embraced it.<sup>29</sup> By the 1890s the situation was different. Medicine had moved away from the therapeutic chaos of the mid-nineteenth century, though the public and doctors alike were still aware of its shortcomings. However, a more unified body of practitioners had been created (partly through legislation) and a number of significant medical innovations had been made which created a series of paradigm shifts that left the medical profession often uncertain and divided, split between established practices and new advances.<sup>30</sup> Any survey of medical history reveals a pattern of clinical, surgical and theoretical advance. For Short the period of change 'opened shortly after Jenner's description of smallpox vaccination [published

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<sup>25</sup> N.Jewson, 'The Disappearance of the Sick Man from Medical Cosmologies', *Sociology*, 10 (1976).

<sup>26</sup> See R.Porter & C.Jones (eds.), *Reassessing Foucault: Power, Medicine and the Body* (1994).

<sup>27</sup> D.Armstrong 'Bodies of Knowledge/Knowledge of Bodies' in Porter & Jones, *Reassessing Foucault*, 18-27.

<sup>28</sup> G.R.Williams, *The Age of Miracles* (1981).

<sup>29</sup> A.Youngson, *The Scientific Revolution in Victorian Medicine* (1979), 30.

<sup>30</sup> T.E.Kuhn, *The Structure of Scientific Revolution* (1970) notes the importance of paradigm shifts in the development of modern science.

1798] and drew to a close with the introduction of diphtheria antitoxin by Behring and Kitasato [1891]'.<sup>31</sup> In the interim numerous bacteriological discoveries were made, though the cure for many diseases was still awaited. Orthodox practitioners began to refine their therapeutic practices, adopting the heresies of homeopathic dosages that they had once condemned, and moved away from 'heroic' therapy to develop the more effective aspects of their old pharmacopoeia.<sup>32</sup> The introduction of anaesthetics in 1846 and the gradual adoption of antiseptics after Lister's work in 1867, changed the practice and perceptions of surgery, making it more effective and invasive.<sup>33</sup> A new approach to disease underpinned these changes and Virchow's ideas marked a final abandonment of humoralism.<sup>34</sup> Illness was beginning to be understood not in terms of the patient's social situation and morality, but in relation to scientific formulations based on contagion. However, medicine was also used to confirm accepted social values, especially those over gender, suggesting a less progressive side of medical advance.<sup>35</sup> A balanced view of Victorian medicine shows that the doctor's main function remained the alleviation of sickness; only through the encouragement medical science gave to the public health campaign could he deal with the underlying causes of sickness.<sup>36</sup>

New practices were not employed uniformly. The medical profession's innate conservatism and the London hospitals' institutional inertia hampered the adoption of new

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<sup>31</sup> S.E.D.Short, 'Physicians, Science, and Status: Issues in the Professionalisation of Anglo-American Medicine in the Nineteenth Century', *Medical History*, 27 (1893), 53.

<sup>32</sup> R.Cooter (ed.), *Studies in the History of Alternative Medicine* (1988); P.A.Nicholls, *Homeopathy and the Medical Profession* (1988).

<sup>33</sup> See D.Hamilton, 'The Nineteenth Century Surgical Revolution', *Bulletin of the History of Medicine*, 56 (1982), 30-40, who counters views that antiseptics was as beneficial as many believe.

<sup>34</sup> R.Maulitz, 'Rudolf Virchow, Julius Cohnheim and the Program of Pathology', *Bulletin of the History of Medicine*, 52 (1978).

<sup>35</sup> See V.Bullough & M.Voght, 'Women, Menstruation and Nineteenth Century Medicine', *Bulletin of the History of Medicine*, 47 (1973) or K.Figlio, 'Chlorosis and Chronic Disease in Nineteenth Century Britain', *Social History*, 3 (1978).

<sup>36</sup> J.M.Eyler, *Victorian Social Medicine* (Baltimore, 1979), 198; A.S.Wohl, *Endanger Lives: Public Health in Victorian Britain* (1983); R.Shryock, *The Development of Modern Medicine* (1947), 234-240.

techniques. A gap remained between science and practice, though the teaching hospitals were attempting to educate their students in the latest medical developments. Therapeutics changed less dramatically than clinical theory so that customary practices remained important even by the start of the twentieth century.<sup>37</sup> The *Lancet* admitted in 1875 that it was ‘scarcely possible for any one man’ to grasp all the advances that medical science had made.<sup>38</sup> The same slow pace of development was seen in the hospital, but different institutions reacted differently to change. The old operating theatre at Guy’s, which had served the hospital since 1726, was only replaced in 1867.<sup>39</sup> However, the governors of the German Hospital were keen to be in the forefront of clinical advance, while at the London a clinical laboratory was opened in 1896 and the tetanus antitoxin was in widespread use in 1894 before its clinical value had been proven.<sup>40</sup> New techniques had a difficult reception and general hospitals were slow to establish specialist departments. Anaesthetics and the use of tracheotomies in the treatment of diphtheria, for example, were not immediately embraced by the entire profession and many small operations by the start of the twentieth century were still conducted without an anaesthetic.<sup>41</sup> The statement of a speaker at the Medical Society of London in 1895, who felt that Lister’s name will shine ‘with an unrivalled splendour on the page of surgical history’, was not shared by all.<sup>42</sup> At St.Bartholomew’s in the 1880s a mixed antiseptic-aseptic regime

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<sup>37</sup> Shryock, *Development of Modern Medicine*, 274-5; 314.

<sup>38</sup> *Lancet*, 2 (1875), 295.

<sup>39</sup> Guy’s Archive, Court of Committee, A3/8.

<sup>40</sup> LH Archive, House Committee, A/5/46.

<sup>41</sup> A.Winter, ‘Mesmerism and the Introduction of Inhalation Anaesthesia’, *Social History of Medicine*, 4 (1991), 1-27; A.Hardy, ‘Tracheotomy versus Intubation: Surgical Intervention in Diphtheria in Europe and the United States 1825-1930’, *Bulletin of the History of Medicine*, 66 (1992).

<sup>42</sup> *Lancet*, 1 (1895), 1323; L.Granshaw, ‘"Upon this Principle I Have Based a Practice": The Development of Antisepsis in Britain’ in J.V.Pickstone, (ed.), *Medical Innovation in Historical Perspective* (1992).

existed side by side with antipathetic attitudes towards antiseptic methods.<sup>43</sup> At other hospitals, a similar dichotomy in medical practices existed with a generational split between the old and new staff. Hospital funding created further problems. With no control over finance, medical staff were in a weak position when it came to suggesting a rise in medical expenditure. Money was not always forthcoming for doctors to establish the services they wanted or buy the equipment they needed. Lucas, chairman of University College Hospital's Management Committee, noted that governors and staff tried to 'conform to the wishes of the other', but financial circumstances often caused problems. At the London in 1861, the governors, purely from financial concerns, threatened to restrict the use of the hospital's microscopes because too many were being damaged and no funds were available for their replacement.<sup>44</sup> The doctors at the Royal Chest Hospital, however, were told in 1883 that a microscope could not be provided because of the hospital's financial situation.<sup>45</sup> Medical progress and finance were not always reconcilable.

Medicine was seen by many contemporaries as a menial and subservient activity, but increasingly medical progress allied the medical profession with a vocabulary that stressed medicine's scientific value.<sup>46</sup> The consultant surgeon to Queen's Hospital, Birmingham, dismissed the value of science to medicine, but others explicitly linked progress in science with progress in medicine.<sup>47</sup> Few patients judged practitioners on their scientific knowledge, but the rhetoric of science became an important part of the medical profession's claim to authority, lending '...support to medicine's assertion that physiology

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<sup>43</sup> T.H.Pennington, 'Listerism, its Decline and its Persistence: The Introduction of Aseptic Surgical Techniques in Three British Teaching Hospitals 1890-99', *Medical History*, 39 (1995), 50-2.

<sup>44</sup> LH Archive, House Committee, A/5/31.

<sup>45</sup> RCH Archive, Medical Committee, A3/1.

<sup>46</sup> M.J.Peterson, 'Gentlemen and Medical Men: The Problem of Profession Recruitment', *Bulletin of the History of Medicine*, 58 (1984), 457-73.

<sup>47</sup> RC on the Medical Acts, *PP* 1882 XIX, 174; H.W.Acland, *The General Relations of Medicine in Modern Times* (1869), 21.

and pathology were subjects increasingly beyond the laymen's comprehension'.<sup>48</sup> Science was the Victorian 'intellectual ratifier of a new world order', a new middle-class ethic that gave social legitimacy to the emergent medical profession.<sup>49</sup> According to Digby, the credibility of the medical profession was '...enhanced by the scientific successes of laboratory medicine and the achievements of hospital surgery'.<sup>50</sup> However, many practitioners gave science a limited role in clinical practice, preferring to retain an emphasis on the value of character.<sup>51</sup> Doctors were aware of their therapeutic impotence, but this did not affect their professional claims. Important differences therefore existed between the profession's public rhetoric and clinical practice that were not always apparent to a lay audience. How hospital governors interpreted these changes is uncertain. Short argues that the rhetoric of science was used by doctors 'to gain autonomy from lay control within the hospital system'.<sup>52</sup> However, where rhetoric stressed the authoritative role of knowledge, most governors were not easily convinced that this necessitated doctors playing an extensive role in hospital management.

### 3. CONTEMPORARIES AND EXTENT OF MEDICAL AUTHORITY

Antivivisectionists and the Humanitarian League warned about the possibility of medical autocracy; others argued that doctors should devote all their time to the treatment of the sick; some stressed the need for increased medical involvement in hospital management.<sup>53</sup>

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<sup>48</sup> Short, 'Physicians, Science, and Status', 67-8.

<sup>49</sup> Cited in Short, 'Physicians, Science, and Status', 61; see C.A.Russell, *Science and Social Change* (1983) for science's impact on popular culture.

<sup>50</sup> Digby, *Making a Medical Living*, 100.

<sup>51</sup> C.Lawrence, 'Incommunicable Knowledge: Science, Technology and the Clinical Art in Britain 1850-1914', *Journal of Contemporary History*, 20 (1985), 503-520, while the disparity between science and practice is illustrated by J.H.Warner, 'Therapeutic Explanation and the Edinburgh Bloodletting Controversy', *Medical History*, 24 (1980), 241-258.

<sup>52</sup> Short, 'Physicians, Science, and Status', 63.

<sup>53</sup> R.D.French, *Antivivisection and Medical Science in Victorian Society* (Princeton, 1975), 349-372; D.Weinbren, 'Against All Cruelty: The Humanitarian League 1891-1919',

The medical profession and press naturally stood in the vanguard of these demands, working on the belief that hospitals ‘determine for the main part the character of the profession’.<sup>54</sup> It was therefore important to extend authority in the very institutions that both educated new entrants and provided the basis for clinical expertise and professional standing.

Wakley complained constantly about the general absence of medical representation and the ‘most extraordinary share in direction of merely medical details’ that governors held without any medical knowledge.<sup>55</sup> As late as 1897 the *Lancet* noted that ‘the services rendered by hospital physicians and surgeons in their professional capacity surely entitle them to seats on the board of management’.<sup>56</sup> The *Lancet*’s opinions helped stir professional grievances and persuade other professional groups and journals to take up the call for representation, though the Royal College of Physicians and the Royal College of Surgeons remained half-hearted. In 1881 the Metropolitan Counties Branch of the BMA passed a resolution that ‘the necessary arrangements as regards treatment should be under the control of the medical staff’.<sup>57</sup> The *BMJ* added its support and though it worried that hospitals robbed general practitioners of business, it regularly campaigned for the medical profession to have ‘a large share in the management of hospitals’.<sup>58</sup> The *Medical Times & Gazette* argued that a medical officer should be in charge of the hospitals’ day-to-day administration because he was more capable than a lay official by virtue of his medical knowledge.<sup>59</sup> Each journal had its own programme for increased medical influence, but all believed that a doctor’s professional body of knowledge gave him the right to be actively involved. Doctors working in the London hospitals existed in a professional

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*History Workshop*, 38 (1994), 98-100.

<sup>54</sup> RC on the Medical Acts, 20.

<sup>55</sup> *Lancet*, 2 (1856), 203.

<sup>56</sup> *Lancet*, 1 (1897), 1289.

<sup>57</sup> *BMJ*, 1 (1881), 312.

<sup>58</sup> *BMJ*, 1 (1882), 313.

<sup>59</sup> *Medical Times & Gazette*, 1 (1879), 148-9.



climate that espoused medical representation, legitimised their demands, and made representation a professional grievance .

Individual doctors expressed their sympathy for medical representation, but few were as public in their support as Charles West. In 1877 West published *On Hospital Organisation*, which outlined his ideas on hospital management.<sup>60</sup> The book focused on children's hospitals and was written in response to his disagreement with the Hospital for Sick Children's governors in 1876 over the extent of medical influence and the role of religion in the hospital. The difference in opinion led to West's resignation.<sup>61</sup> *On Hospital Organisation* was a polemic, but it encapsulated many of the medical profession's concerns over their role in hospital management. The book focused on a careful plan for the administration of children's hospitals, but the first fifteen pages outlined West's ideas on medical representation. Harmony, he believed, was the source of efficiency and to achieve this the administration had to be divided between a medical committee and the governors. Medical representatives would be limited to doctors holding honorary posts to prevent the governors from being outnumbered, but even in the discussion of non-medical issues West believed that the medical staff should be represented on the basis of their scientific knowledge.<sup>62</sup> The *Medical Examiner* believed that these ideas would create a 'stir in the professional world', but they received a favourable reception because they mirrored professional concerns.<sup>63</sup>

Calls for medical representation, however, also came from outside the medical profession. Dr Lichtenberg, a physician at the German Hospital, argued in 1891 that many of the German Hospital's subscribers supported medical representation, and one writer to *The Times* in 1878 claimed that the public were withholding their subscriptions until doctors were given a greater role in hospital management.<sup>64</sup> In fact Lichtenberg was campaigning for medical representation in the German Hospital, while the assessment in

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<sup>60</sup> C. West, *On Hospital Organisation* (1877).

<sup>61</sup> GOS Archive, Press Cuttings, 8/151.

<sup>62</sup> West, *Hospital Organisation*, 7-15.

<sup>63</sup> Cited in GOS Archive, Press Cuttings, GOS/8/154.

<sup>64</sup> *Charity Record & Philanthropic News*, 11 (1891), 60; *Times*, 23 January 1878, 11.

*The Times* was farfetched. Both, however, pointed to a non-medical interest in medical representation, reflecting society's increasing acceptance of professional service. Without such support the medical profession's claims would have appeared less acceptable. Many non-medical journals, albeit reluctantly, came out in support of the idea. One anonymous writer in the *Quarterly Review* in 1893 argued that 'hospitals exist for patients, and who but the doctor can say what the patient requires?'<sup>65</sup> The author's enthusiasm rivalled that of the medical profession's, but other contemporaries were more qualified in their support. The *Hospital* adopted a moderate stance. It called for the establishment of medical committees to represent doctors' interests, an opinion that reflected many governors' attitudes.<sup>66</sup> The *Charity Record & Philanthropic News* firmly supported medical representation, though it was uncertain what form it should take. Individuals had their own schemes. Henry Burdett, speaking at a meeting of the BMA in Dublin in 1881, added his influential support and called for greater cooperation between the medical and lay branches of the hospital.<sup>67</sup> Burford Rawlings, addressing a conference on hospital administration two years later, came to a more precise conclusion. He believed that hospitals should be managed by a small elected committee; 'supreme authority' should rest with a non-professional body, with the medical staff being consulted in all decisions. Qualified support was given to medical representation, but other speakers at the conference came out in favour of the system adopted at St.Thomas's where the medical staff had a seat on the House Committee.<sup>68</sup> Others put forward more systematic plans as part of a general reform of London's hospitals. Frederick Mouat was a key figure in these discussions. As part of his detailed plan to reorganise the structure of healthcare in London, he suggested that all hospital committees should have a medical element. He asserted that medical superintendents should run hospitals on a daily basis and doctors unconnected with the institution should be on its management because of their unbiased

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<sup>65</sup> *Quarterly Review*, 177 (1893), 471.

<sup>66</sup> *Hospital*, 1 March 1890, 350.

<sup>67</sup> *BMJ*, 2 (1881), 646.

<sup>68</sup> J.L.Clifford Smith (ed.), *Hospital Management* (1883), 10-21.

‘technical and special knowledge’.<sup>69</sup> Mouat’s views were widely criticised, but the medical press was heartened by his recommendations.

The medical and lay discussion of hospital management agreed that increased medical representation was desirable. Doctors, however, were excluded from one area of management. The *Hospital* warned that ‘were it not that the financial necessities render lay cooperation indispensable’, doctors would want full control.<sup>70</sup> In the demands for increased medical representation no attempt was made to encroach on the governors’ financial control. Doctors, in asserting their professional knowledge, recognised that hospital finance was the governors’ own professional sphere. No indication is given of whether this was a recognition of the hospitals’ continued reliance on voluntarism, but it does support a view that separate spheres existed in hospital management that were respected in the hospitals’ internal politics.

#### 4. MEDICAL INFLUENCE AND CONFLICT

A survey conducted by the *Lancet* in 1874 found that 15 of the 22 hospitals in London with over 50 beds had a doctor in their management.<sup>71</sup> However, a distinction must be made between hospital types and between formal and informal authority.

The endowed hospitals had a conservative approach to their administration. Here, according to the *BMJ*, the medical staff had ‘no voice in the management’ and were ‘under the absolute control of a set of men who... are entirely without knowledge of hospital affairs’.<sup>72</sup> Endowed hospitals were reluctant to allow their doctors any administrative role. The situation was not created by the nature of their funding, which in theory should have freed the governors from subscriber pressure to administer the hospital on philanthropic lines. It was produced by these institutions’ age. The endowed hospitals were dominated by their history and by tradition, factors which encouraged

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<sup>69</sup> F.Mouat & H.S.Snell, *Hospital Construction and Management* (1883), 10-11.

<sup>70</sup> *Hospital*, 1 March 1890, 350.

<sup>71</sup> *Lancet*, 1 (1874), 420.

<sup>72</sup> *BMJ*, 1 (1887), 70.

institutional inertia and hostility to change. At Guy's, as noted below, the position did change in 1880, but at St.Bartholomew's the doctors remained excluded from a formal managerial position. It was not until 1843 that a medical committee was established and even moderate suggestions for a joint subcommittee on medical appointments in 1887 proved unacceptable to the governors.<sup>73</sup> Superficially, the hospital's rules offered the medical staff the chance to stand as governors, but this was not matched with the possibility of being included on any of the managing committees. The *Lancet* criticised the medical staff for their timidity and the doctors felt oppressed by the system at the hospital.<sup>74</sup> Doctors in the newer voluntary hospitals were in a better situation. From 1863 the medical staff at University College Hospital were allowed to send three representatives to the Management Committee.<sup>75</sup> These representatives were not given voting rights, but from the 1860s onwards the medical staff were increasingly invited to discuss any measures that affected the hospital's medical administration. A distinction clearly existed between the endowed hospitals and the eighteenth-century hospitals.

Specialist hospitals were in a different position. The *BMJ* felt that at specialist hospitals doctors exercised a 'quasi-private and semi-autocratic government' where they were both 'its practical ruler and official superintendent'.<sup>76</sup> Specialist hospitals did have a high degree of medical involvement in their administration, but the *BMJ*'s assessment was an exaggeration. When the Hospital for Sick Children was opened in 1852, the extent of formal medical influence was limited. However, a series of changes in 1854, 1877 and 1894 saw an extension of the medical staff's formal participation.<sup>77</sup> From 1855 the medical staff were represented in their own Medical Committee and the three senior doctors had a position on the Management Committee. By 1877 medical representatives sat on the Drug, the Management, the Building, and the House committees.<sup>78</sup> In 1894,

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<sup>73</sup> SBH Archive, Governors' Minutes, Ha/1/26.

<sup>74</sup> *Lancet*, 2 (1869), 643.

<sup>75</sup> UCH Archive, Medical Committee, A1/1/2.

<sup>76</sup> *BMJ*, 2 (1877), 654.

<sup>77</sup> GOS Archive, Committee of Management, GOS/1/2/4-20.

<sup>78</sup> GOS Archive, Press Cuttings, GOS/8/151; Medical Committee, GOS/1/5/7.

to solve the problem of jurisdiction over appointments, a joint committee was established.<sup>79</sup> The medical staff at the Royal Chest Hospital had to wait until 1867 until a Medical Committee was appointed, but a medical representative had always been on the main committee. From the 1880s onwards the hospital's administration was effectively split between the Medical Committee and the Management Committee and all other committees had a doctor sitting on them.<sup>80</sup> The need for medical representation was confirmed by these hospitals' specialist nature. In the new specialist hospitals the business experience that gave governors the right to control general hospitals was a poor substitute for medical knowledge. Institutionally, specialist hospitals required a greater degree of medical participation. The governors' position was also initially tempered by the fact that the founding inspiration for these institutions was invariably a medical one.<sup>81</sup> In specialist hospitals, governors were in no position to argue, except over expenditure.

The absence of a formal managerial position did not preclude all medical influence. Doctors exercised a certain autonomy over their own working environment, controlling the allocation of beds and the standard of medical education. They also had an informal influence on the hospitals' administration through advice and recommendations which produced a constant flow of information between the hospitals' medical and non-medical departments. Clark, an assistant surgeon at St.Bartholomew's, told the Select Committee on Metropolitan Hospitals in 1890 that in most hospitals doctors were heeded, but not officially.<sup>82</sup> Influence at an informal level, with a voluntary inclusion of the medical staff by the governors in the decision making process, could be considerable.

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<sup>79</sup> GOS Archive, Joint Committee, GOS/1/7/1.

<sup>80</sup> RCH Archive, Medical Committee, A3/1-2; Governors' Minutes, A1/5-8.

<sup>81</sup> L.Granshaw, "'Fame and Fortune by Bricks and Mortar": the Medical Profession and Specialist Hospitals in Britain 1800-1948' in L.Granshaw & R.Porter (eds.), *The Hospital in History* (1989).

<sup>82</sup> SC of the House of Lords on the Metropolitan Hospitals, 1st Report, *PP* 1890 XIX, 134.

At the German Hospital, the doctors exercised a significant informal influence even though they were excluded from formal participation in management until 1891.<sup>83</sup> The governors opposed the inclusion of the medical staff in the administration because they argued that the existing system worked well.<sup>84</sup> The medical staff met regularly in a Medical Committee until the 1870s when meetings became erratic. No meetings were held between 1884 and 1891, but despite this they were able to shape the hospital's development.<sup>85</sup> Deprived of formal influence, the doctors communicated their ideas to the governors through personal representation and letters. The governors in turn consulted them on matters from the admissions of syphilitic patients to the supply of gas.<sup>86</sup> A similar situation existed at other hospitals. At St.Bartholomew's and Guy's the medical staff had to rely upon informal influence to exert any influence. Doctors at St.Bartholomew's communicated directly with the treasurer and at Guy's their views were interpreted by the medical superintendent, or through direct communication with the treasurer. Until the foundation of a joint management committee for the medical school in 1876, the doctors at the London were excluded from the hospital's management.<sup>87</sup> Between 1836 and 1867 they used the Physicians and Surgeons Book to bring matters to the governors' attention, followed by a system of letters.<sup>88</sup> This suggests a clear distinction between the medical and lay administration. In formal terms, the medical staff had no power over their working environment. All decisions had to be ratified by the governors, but all matters relating to the hospital's medical administration were given to the doctors to discuss, though the governors did not always accept their views. Grievances were discussed on a face-to-face basis. The governors reprimanded any doctor who did not meet their idea of adequate attendance, but when Wordsworth, a surgeon, complained in 1853 about the problems cancer patients faced in being admitted, he was

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<sup>83</sup> GH Archive, Annual General Court, A/4/2.

<sup>84</sup> *BMJ*, 1 (1890), 375.

<sup>85</sup> GH Archive, Medical Committee, Mc/16/1.

<sup>86</sup> GH Archive, Medical Committee, Mc/16/1.

<sup>87</sup> LH Archive, Medical Committee, MC/A/1/3.

<sup>88</sup> LH Archive, Physicians & Surgeons Book, A/17/7.

given a special dispensation to admit such patients. The decision required a further change in the hospital's admissions procedure that left the medical staff in a stronger position.<sup>89</sup> The governors were prepared to refuse requests from the medical staff without discussion. In 1860 the doctors pressed for an ophthalmic department, but the scheme was rejected as the governors argued that the hospital had enough problems allocating beds for accident cases.<sup>90</sup> However, from the mid-1860s onwards they were generally willing to accede to the doctors' requests if a suitable case was made and money was available. Control rested with the governors, but at the London and at other metropolitan hospitals the administrative structure concealed a flow of information and influence from the doctors.

Medical authority was at its height both at an informal and a formal level when a decision needed a medical opinion. Governors, ill-equipped to make an effective decision on medically related issues, were forced to consult their medical staff. At the Hospital for Sick Children in 1895, the Medical Committee was asked to investigate the duties of the Registrar and the House Surgeon, consider the nursing arrangements, appoint two clinical assistants, and provide the London School Board with medical certificates for children under the hospital's care.<sup>91</sup> Not all doctors were consulted to this extent, but even at St.Bartholomew's the hospital's effective administration often required a medical opinion. Sydney Waterlow admitted that the governors of St.Bartholomew's were '... guided, and I think I may say they are always anxious to be guided, by what they can learn through me is the view of the medical council'.<sup>92</sup> When the General Committee at University College Hospital wanted to establish skin and urinary special wards for clinical teaching in 1859, they sought the Medical Committee's advice.<sup>93</sup> Doctors were prepared to use their professional knowledge under these situations. When a matter was presented to them that they disagreed with, they could retreat behind the claim that a change could

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<sup>89</sup> LH Archive, House Committee, A/5/27.

<sup>90</sup> LH Archive, House Committee, A/5/31.

<sup>91</sup> GOS Archive, Medical Committee Papers, GOS/1/5/52.

<sup>92</sup> SC on Metropolitan Hospitals, 1st Report, 162.

<sup>93</sup> UCH Archive, UNOF/2/3 (i).

not be supported without 'due regard to the welfare of the patient[s]'.<sup>94</sup> The justification for action or inactivity based on medical knowledge was sometimes hard to separate from the doctors' professional interests.

Doctors in the London hospitals increasingly seemed dissatisfied with informal influence. Peterson suggests that there was a transformation in the 'relations of governors and medical men' where the lay administrators accepted the doctors' 'right to power based on their special knowledge'.<sup>95</sup> However, she does not illustrate the process by which the transformation occurred. The experiences of London's hospitals suggest that increased medical influence was rarely inevitable or followed a smooth course.

Marland in her study of medical charity in Wakefield and Huddersfield feels that 'although the lay officers do seem to have been the dominant force in decision-making, the two groups cooperated well at committee and general meetings, presenting a uniform front on such important issues as admission policies, organisation and funding'.<sup>96</sup> For her, the absence of conflict typifies the relationship between lay and medical officers, a view shared by Abel Smith.<sup>97</sup> More realistically, Morris has identified the hospital as an arena of conflict.<sup>98</sup> Hospitals offered manifold opportunities for tension as the hospitals' philanthropic nature increasingly jarred with its new medical functions. The medical profession's steady rise in 'power and influence and respect', noted by Gladstone in 1890, seemed to obscure the friction that periodically developed.<sup>99</sup> Other observers were not so sanguine and readily identified conflict as part of the reason for the hospitals' financial problems.<sup>100</sup> Scandals did adversely affect hospital income, but conflict had a more

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<sup>94</sup> LH Hospital, Medical Committee, Mc/A/1/2.

<sup>95</sup> Peterson, *Medical Profession*, 187.

<sup>96</sup> H.Marland, *Medicine and Society in Wakefield and Huddersfield 1780-1870* (Cambridge, 1987), 330-1.

<sup>97</sup> Abel Smith, *The Hospitals*, 32-45.

<sup>98</sup> R.J.Morris, 'Organisation & Aims of the Principal Secular Voluntary Organisations of the Leeds Middle Class 1830-1851' (DPhil, Oxford, 1970), 182.

<sup>99</sup> *Charity*, April 1890, 274.

<sup>100</sup> *Charity*, November 1887, 151.



marked effect on internal management, becoming the main vehicle through which doctors increased their formal institutional authority.<sup>101</sup> Where tension did not erupt into an open dispute, the medical staff's influence often remained stunted, as at St.Bartholomew's. For doctors to extend their formal influence, an internal crisis and the threat of resignation seemed necessary.

The fault did not always rest with the governors. *Guy's Hospital Gazette* admitted that 'it is, no doubt, often difficult for laymen to appreciate the aims and needs of the medical workers'. However, such statements did little to reduce tension as doctors were not always sympathetic to other concerns.<sup>102</sup> They could be obstinate, inflexible and arrogant, considering 'their work as a matter of highest importance to the hospital, and in its nature not to be understood by the committee, and, therefore, not to be found fault with...'.<sup>103</sup> At the German Hospital, Dr Straube was summarily dismissed in 1854. The governors believed that he had acted improperly towards one of the female patients, while Straube asserted that he was only examining the patient.<sup>104</sup> The *Lancet* introduced a cautionary note in 1859, explaining that the lay might not always grasp medical science's importance, 'but then the modesty that befits science... suggests that we may not always be right'.<sup>105</sup> It was a view that was not always heeded. Doctors disliked any external interference and resisted attempts to impose new routines on them. Even the governors' practice of visiting wards, which they saw as an important part of their philanthropic responsibility, aroused opposition because it was seen as disruptive. Howie has suggested that 'visiting' was a means to ensure that the hospital environment was regulated and complaints were investigated, but for the medical staff it suggested that they were being monitored.<sup>106</sup>

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<sup>101</sup> See pages 169-72.

<sup>102</sup> Cited in *Hospital*, 1 November 1890, 72.

<sup>103</sup> *Hospital*, 15 March 1890, 381.

<sup>104</sup> GH Archive, Hospital Committee, A/2/2.

<sup>105</sup> *Lancet*, 1 (1859), 634.

<sup>106</sup> W.B.Howie, 'Complaints and Complaints Procedures in the Eighteenth and Early Nineteenth Century Provincial Hospitals', *Medical History*, 25 (1981), 345-62.

Conflict between governors and doctors took many forms, erupting at different points in an institution's history when the medical staff felt their collective interests threatened. From the 1850s onwards, doctors increasingly intervened in the admissions process, extending their influence from the casualty departments and internal allocation of beds. Governors seemed willing to let the letter system fall into decline and were aware that 'it would be a dangerous thing for a lay person to say that a case should be rejected which the doctor said should come in'.<sup>107</sup> Problems, however, were encountered over the discharge of patients because governors sought to keep the number of cases high to attract charitable contributions. The *Hospital* admitted that only a medical practitioner was 'practically competent to say when discharge is safe and right', but many governors attempted to impose a restriction on the time patients spent in hospital.<sup>108</sup> One writer in the *Contemporary Review* believed that it was difficult for any doctor to extend a patient's stay beyond three months.<sup>109</sup> This was not always the case and here medical interests clashed with financial concerns. At the London the medical staff had control over the renewal of admission rights, but in 1859 the governors complained that this created an intolerable pressure on the hospital's resources. In response the doctors argued that only through full control could proper treatment be provided.<sup>110</sup> The medical staff at the Royal Chest Hospital successfully defended any patient's long stay purely on medical grounds.<sup>111</sup> When doctors asserted their professional knowledge over a patient, governors reluctantly agreed to extend treatment. However, they ensured that all extensions still had to have their approval, creating tension with the medical staff who believed that all aspects of patient care should be under their authority. Conflict was shaped by the medical profession's evolving sense of identity and its changing concerns, emerging in areas where medical authority was questioned, or an existing role in administration seemed threatened.

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<sup>107</sup> SC on Metropolitan Hospitals, 1st Report, 521.

<sup>108</sup> *Hospital*, 23 April 1887, 61.

<sup>109</sup> R.Brundell Carter, 'The London Medical Schools', *Contemporary Review*, 34 (1878/9), 591.

<sup>110</sup> LH Archive, House Committee, A/5/30.

<sup>111</sup> RCH Archive, Medical Committee, A3/1-2.

Most hospitals in London had a troubled evolution. The Royal Chest Hospital's history was particularly punctuated by friction between its lay administrators and medical staff. In 1867 three doctors resigned claiming an autocratic system of management; in 1883 the governors faced threats of mass resignation. Concerned about attendance, they had attempted to enforce the doctors' visiting times and this was combined with new regulations over prescriptions after accusations that one of the doctors had been experimenting on the patients. The medical staff immediately went on the defensive, claiming an 'uncalled interference with those whose practice and experience should qualify them to be the best judges of what is proper in medical treatment'.<sup>112</sup> The crisis was only resolved with a compromise that left both sides professing victory. The governors acknowledged some of the doctors' grievances and attempted to meet them, while the doctors' attendance improved. Increasingly, the governors seemed willing to consult their medical staff and in the discussion over the hospital's new rules throughout 1885 many of the doctors' suggestions were adopted. Medical representatives were appointed as ex-officio members of the hospital's committees when the new rules were enforced in March 1886 and all appointments were referred to the Medical Council.<sup>113</sup> The doctors' stubbornness placed them in a favourable position and when a new crisis emerged in 1889 over the secretary's allegations that they were turning the hospital into a teaching hospital and admitting 'unsuitable' cases, the governors came to their support.<sup>114</sup> The conflicts that emerged at the Royal Chest Hospital and at other hospitals, though embarrassing for the governors, attracted little public attention and remained essentially internal disputes. However, the nursing dispute at Guy's, which lasted from December 1879 to September 1880, had a more striking impact on the public. The dispute, which attracted professional and public attention and outrage, exemplified the process by which the medical profession assumed a greater role in hospital management.

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<sup>112</sup> *Lancet*, 2 (1867), 400-1; RCH Archive, Medical Committee, A3/1.

<sup>113</sup> RCH Archive, Medical Committee, A3/1.

<sup>114</sup> RCH Archive, Governors' Minutes, A1/7.

## 5. THE NURSING DISPUTE AT GUY'S

When Guy's launched its first public appeal in 1886, Dr Pavy testified 'that the greatest unanimity now existed between the medical and nursing staff... that at the present time the nursing staff was everything that could be desired'. Ironically seven years earlier a similar system had incited a virtual state of 'civil war'.<sup>115</sup> Most historians have seen the nursing dispute as a chapter in the history of nursing, not part of the history of the medical profession.<sup>116</sup> Peterson, however, shares the Victorian analysis that the dispute was more than a typical struggle. She sees that the 'fundamental issue [in the dispute] was the authority of the medical officers', but for her this only emerged from the 'summer of 1880'.<sup>117</sup> However, her analysis hides the fact that from the start the issue was not over nursing, but over the question of authority within the hospital and the role of the medical profession in hospital administration.

The dispute erupted over the appointment of Margaret Burt by Lushington in December 1879 after the old matron had retired after 34 years of service. Lushington, since his appointment as treasurer in 1876, had absorbed himself in the hospital's management and set about instilling 'the principles of good management and economy' that he felt were absent at Guy's.<sup>118</sup> He worked with an apparent sympathy for the doctors' interests and in return they gave their cooperation. After three years of intense activity, Lushington turned his attention to the deplorable system of nursing. Intermittent nursing reforms had been attempted prior to Burt's appointment and had been partly motivated by the medical staff's desire to promote efficient patient care. However, they had not proved effective. Reliable trained women were difficult to find and progress was hampered by the governors' fitful approach to management. Lushington believed that the basic problem stemmed from the lack of a 'competent female in authority'.<sup>119</sup> In Burt,

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<sup>115</sup> *Lancet*, 2 (1880), 507-8.

<sup>116</sup> In particular see J. Moore, *A Zeal for Responsibility* (1988), 53-97.

<sup>117</sup> Peterson, *Medical Profession*, 180.

<sup>118</sup> Guy's Archive, Letter, A221/3.

<sup>119</sup> Guy's Archive, Letter, A221/3.

a trainee of St.John's House which was committed to promoting training and improving working conditions for nurses, he hoped to find his 'competent female'.<sup>120</sup> St.John's House was in the vanguard of nursing reform and Burt had nine years' experience including her successful spell as the reforming lady-superintendent at the Leicester Infirmary.<sup>121</sup> Lushington was not disappointed and Burt immediately set about her work. Certain changes were designed to improve the nurses' working conditions with the aim of creating a unified body, centralised under the matron's authority; others to '...secure a thorough training of probationers of whatever social rank, to diminish the menial work of the trained nurses, which had been a serious hinderance to their proper duties in former times'.<sup>122</sup>

Lushington's enthusiasm was not shared by the medical staff, who were prejudiced against the new matron before her arrival. They saw her as a threat, a view based not on personal acquaintance since only eight of the twenty doctors met her during the dispute, but on her training and work at Leicester. Their antagonism was symptomatic of the medical profession's latent hostility to nursing reform. Whether the new arrangements were instituted by trainees from the Nightingale School, or by the nursing sisterhoods, the medical staff generally put up a spirited defence. At the centre of many of these disputes were the nursing sisterhoods and in particular St.John's House.<sup>123</sup> Several common grievances can be identified in all these conflicts. The *BMJ* argued that

as mere matter of fact, ladies, as a rule, do not make first-rate nurses; and the reasons are obvious. With the rare exceptions they are essentially *amateurish*; or, if very much in earnest are apt to be dominated by some principle or power, not necessarily an ally to be trusted in the management of the sick. Ladies take to nursing, as a rule, from slightly morbid motive; they are "disappointed", or they want something with which to kill *ennui*, or they have religious convictions on the subject; none of which

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<sup>120</sup> C.Helmstadter, 'Robert Bentley Todd, Saint John's House, and the Origins of the Modern Trained Nurse', *Bulletin of the History of Medicine*, 67 (1993), 299-301.

<sup>121</sup> *BMJ*, 2 (1879), 1045; see also Moore, *Zeal for Responsibility*.

<sup>122</sup> Guy's Archive, General Court, A1/3.

<sup>123</sup> Moore, *Zeal for Responsibility*, 1-39, 101-169.

sentiments, we may venture to say, are likely to result in producing good *staying* workers.<sup>124</sup>

The introduction of trained nurses, often with an independent income and a higher social status than the medical staff, was perceived as a challenge to the medical profession's authority and habitual practices. Under the old system, nurses were accountable to the doctor; under a reformed system their control was in doubt. Part of the problem lay in a conflict of professional ideals. Any scheme of nursing reform involved a change in the hospital's administration and for a matron to be successful, a conflicting power base had to be established, challenging the doctors' conception of legitimate authority. According to a prime mover in the Nightingale Fund, 'doctors are very liable to imagine that because they are the proper people, and the only persons, to give orders respecting the treatment of patients, therefore they must have the entire control of staff'.<sup>125</sup> The matrons' and nurses' claim to autonomy was intolerable for the status-conscious medical profession, as they 'feared that these educated women would undermine their authority'.<sup>126</sup> At the height of the dispute, the *BMJ* wrote that the staff at Guy's were championing a principle in resisting the self-styled lady-superintendents, who had an 'exaggerated view of their own importance', and were tainted with 'conceit, insubordination, and self-will'.<sup>127</sup> The dispute, as the *Lancet* realised, was therefore more than a parochial disagreement over the nature of reform.

Opposition came rapidly in a series of letters to Lushington. The medical staff overlooked the fact that they had earlier campaigned for reform and initially argued that the nurses had been 'tyrannised' by Burt's overbearing manner. However, the manipulation of the nurses' grievances and an apparent concern for patient welfare concealed other interests. The medical staff 'utterly opposed' the matron's attempts to establish what they saw as a 'sisterhood to which everything is subservient' as this worked in opposition to 'the great principles which have always been in operation at

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<sup>124</sup> Cited in B. Abel Smith, *A History of the Nursing Profession* (1960), 27.

<sup>125</sup> Cited in M. Baly, *Florence Nightingale and the Nursing Legacy* (1986), 47.

<sup>126</sup> Abel Smith, *Nursing Profession*, 27.

<sup>127</sup> *BMJ*, 1 (1880), 289-90, 400.

Guy's'.<sup>128</sup> The doctors recognised the governors' authority, but felt that they possessed a level of medical knowledge far superior to Lushington or 'a stranger from a country infirmary'.<sup>129</sup> Lushington countered, denying the notion of a sisterhood and arguing that the new regulations differed little from the previous rules that had suffered from 'a great laxity in observance'.<sup>130</sup> He was not unsympathetic to the doctors' interests, but refused to dismiss Burt or alter the new nursing system. Between Lushington and the doctors there was a clash of interests over the legitimate spheres of authority.

Over the following months the medical staff redefined their opposition. There was a gradual shift from a conceptual attack on nursing sisterhoods to an opposition based on the material effects of the reforms, which were shown as jeopardising treatment. At a three day inquiry in March 1880 the medical staff presented their accumulated evidence. Particular attention was given to the new procedures where patients were woken at five in the morning or moved so they could be washed. Individual cases were cited where the relocation of trained nurses had left an unskilled probationer in charge, resulting in inadequate care.<sup>131</sup> The governors were not moved. However, the death of Louisa Morgan, a patient, in July only added to the doctors' case. It was reported that Ingle, a new nurse, had dragged Morgan to the bathroom, placed her in a cold bath for twenty minutes and then, after adding a little warm water, left her there for another hour. Dr Pavy's medical testimony claimed that Morgan had died three days later, not from consumption for which she had been admitted, but from a 'tubercular and inflammatory disease of the brain', a disorder he attributed to the shock of the bath. Sir William Gull, physician to the Prince of Wales and also on the hospital's staff, refuted this opinion. It must be wondered how much Pavy was influenced by his desire to discredit the new nursing arrangements, though it was Gull who was attacked as biased.<sup>132</sup> Ingle explained that she had treated the patient for hysteria, a statement that incensed the medical staff as

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<sup>128</sup> Guy's Archive, Letter, A219/1.

<sup>129</sup> Guy's Archive, Letter, A219/7.

<sup>130</sup> Guy's Archive, Letter, A219/3.

<sup>131</sup> Guy's Archive, General Court, A225/1-3.

<sup>132</sup> *BMJ*, 2 (1880), 307.

it appeared to be a direct admission that the new nurses laid claim to their medical knowledge. She did not make a good impression on the jury who convicted her of manslaughter.<sup>133</sup> *The Times* made the inevitable connection ‘that this unfortunate case is not an unnatural result of the controversy about nursing...’.<sup>134</sup> The doctors’ allegations that ‘the new nursing system would prove not only harsh to individuals, but detrimental to the welfare of our patients’ was not entirely supported, for Ingle had acted on the advice of an ‘old’ sister.<sup>135</sup> This evidence was ignored; it was the impression that was important. For the medical staff and their adherents the case successfully supported their claim ‘... to exercise supreme control over the nursing’.<sup>136</sup> In their view, nursing was an extension of treatment and therefore had to be under their professional control. The case implied that when they were not consulted the outcome would be disastrous. Medical knowledge and clinical practice once more justified professional concerns.

An apparent concern for patient welfare concealed the doctors’ real grievances. The medical staff believed that the new regulations destroyed the ‘traditional relationship between doctors and nurses’ and they feared that they would be reduced to a subordinate position.<sup>137</sup> The movement of probationers and nurses between wards, a practice considered necessary for their training, was seen as a direct threat to the doctors’ working practices. Under these conditions they could no longer allocate nurses as they wanted.<sup>138</sup> They asserted that

whatever power we had possessed as officers of the Medical Staff with respect to the nursing has been taken from us, if not directly, at all events indirectly, by the matron who has been placed over us, who made rules entirely at variance with our former rules.<sup>139</sup>

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<sup>133</sup> *BMJ*, 2 (1880), 170-1.

<sup>134</sup> *Times*, 7 August 1880, 9.

<sup>135</sup> Guy’s Archive, Letter, A219/13.

<sup>136</sup> *Times*, 7 August 1880, 9.

<sup>137</sup> Cited in Moore, *Zeal for Responsibility*, 60.

<sup>138</sup> Guy’s Archive, Letters, A223/1-14.

<sup>139</sup> Guy’s Archive, General Court, A225/1.



Under threat, the medical staff's criticisms went further than the daily management of the wards. From the start opposition stemmed from the fact that the reforms had been framed without due courtesy and set up 'without reference to us'.<sup>140</sup> This contradicted a memorandum from Lushington which claimed that 'there is no wish... to establish new rules without the concurrence of the Governors, and the fullest consideration of the wishes of the Medical Staff'.<sup>141</sup> The medical press focused on this issue. The *Medical Times & Gazette* reflected general opinion in the profession when it remarked that 'the physicians and surgeons must be consulted about nursing systems, which should certainly be controlled by them rather than by "the torrents of public opinion"'.<sup>142</sup> Even those who supported trained nurses found 'absolute subordination' essential.<sup>143</sup>

Once the question of responsibility and authority had been raised over one issue, the dispute became an arena for a heated discussion on medical representation. The medical press, particularly the *BMJ*, pointed to the wider implications:

sooner or later, it must be recognised in the City hospitals... that the medical officers of the hospital are as much its governors as a layman who administers the funds; that it is essential, for the truly harmonious and effective working of such a hospital, that the medical officers should sit at the Governors' board with the lay Governors; that a mere donation of £30 or £50 does not constitute a unique and particular fitness for governing a medical institution... but that living in its wards, the habit of dealing with its patients, with a personal knowledge of what is wanted to make it efficient, are as important factors in the determination of the rules of government as are merely financial qualifications.<sup>144</sup>

Only over finance was the *Lancet* willing to concede that the governors might have a greater claim to knowledge.<sup>145</sup> Though the treasurer was not the despot that the Charity Commission had claimed in 1840, he was the executive authority and the doctors only had

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<sup>140</sup> Guy's Archive, Letters, A219/1.

<sup>141</sup> Guy's Archive, Memorandum, A221/1.

<sup>142</sup> *Medical Times & Gazette*, 1 (1880), 429.

<sup>143</sup> O.Sturges, 'Doctors and Nurses', *Nineteenth Century*, (1880), 1093.

<sup>144</sup> *BMJ*, 2 (1880), 593.

<sup>145</sup> *Lancet*, 2 (1880), 583.

a degree of informal influence.<sup>146</sup> Informal influence was better than no influence and the nursing reforms appeared to be a complete reversal of a position the doctors had been able to build up. On these grounds they called for consultation in all matters affecting medical practice, especially nursing. From an awareness that they were basing their opposition on a moral and medical prerogative to intervene and had no legal right under Guy's Act of Incorporation to interfere, they nevertheless sought a greater administrative role. This was expressed as a demand for representation and the medical profession united behind them on these grounds, though actual support was limited to sympathetic resolutions from the branches of the BMA and encouraging articles.<sup>147</sup>

The doctors agreed that 'the nursing of our patients is so closely connected with our treatment of disease that we are not exceeding our duty in being deeply concerned on the subject', but Lushington had other views.<sup>148</sup> In his opinion,

the medical staff have... outstepped the limits of their province in commenting on the minutest details of my administrative proceedings, in impugning the justice of my decisions when dealing with contumacious servants, and in treating with marked disrespect the chief female authority in the Hospital.<sup>149</sup>

Lushington's intractable attitude is not surprising. He had been used to his plans being carried out without dissension, and the medical staff's opposition was the first concerted attack on his authority. This was confirmed by the medical students' demonstration on 3 July 1880 which was phrased in personal, rather than institutional terms.<sup>150</sup> It was not only the doctors who felt themselves threatened. Naturally they did not see matters from Lushington's perspective, but in August 1880 they admitted that the dispute had brought his authority into question.<sup>151</sup>

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<sup>146</sup> 32nd Report of the Charity Commission, *PP* 1840 VI, 780.

<sup>147</sup> Guy's Archive, Letters, A219/24.

<sup>148</sup> Guy's Archive, Petition, A222/1.

<sup>149</sup> Guy's Archive, Letter, A219/18.

<sup>150</sup> Guy's Archive, Letter, A229/6.

<sup>151</sup> Guy's Archive, Letter, A219/25.

The governors reacted slowly as they were prepared to allow Lushington, as in the past, to make all the decisions. Only Lord Cardwell felt sufficiently concerned to resign and most continued their languid attitude to the hospital's management, though attendance at meetings did increase. No opinion was expressed, but the governors placed 'entire confidence' in Lushington, trusting 'the medical staff will find that the future good management of the hospital will thereby be promoted, and that nothing will occur to interfere with the continuation of the cordial understanding between the treasurer and the medical and surgical staff'.<sup>152</sup> It was a forlorn hope as the tradition of informal cooperation had already broken down. Attempts to defuse the situation faltered and in March 1880 the governors appointed a lay subcommittee to investigate.

In April, before the committee reported, the main managing body accepted the medical staff's opinion that a sister should be responsible for each ward, able to administer medicine along their guidelines, and remain in the same ward with no night duties unless 'the interests of the hospital absolutely require'. The new regulations were seen as erroneous and centralisation as undesirable. It was admitted that reform required greater collaboration with the medical staff. This was not enough to placate the doctors. With their collective pride offended they continued to insist that Burt be dismissed.<sup>153</sup> The governors refused. The doctors' stubborn attitude in April seemed far less justifiable by June when the subcommittee's report was submitted, a month before it was made public. Reform was identified as a priority and the medical staff's anxiety was acknowledged. It was admitted that reform had been initiated 'without sufficient consultation and preparation', that the new matron had not been introduced to the medical staff, and that she had worked under the false assumption that her efforts 'would be acceptable...'. However, no 'sufficient justification for the difficulties which have existed between the medical staff and matron' was found.<sup>154</sup> The committee felt that there had been no fundamental change in the existing rules and that the effect of the reforms had been exaggerated. While the general tone of the report dismissed the dispute, several positive proposals were made. The hospital's previous pattern of management was recognised as

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<sup>152</sup> Guy's Archive, Court of Committee, A3/10.

<sup>153</sup> Guy's Archive, Court of Committees, A3/10.

<sup>154</sup> Guy's Archive, Subcommittee Report, A233/1.

inadequate. It was admitted that the governors were not always the best body to make informed decisions on medical matters. The solution was to invite the staff to participate formally in the hospital's management to ensure that reorganisation would be satisfactory to both parties. A joint taking-in committee was recommended, revitalising a body that had become redundant as the doctors had replaced its official control of admissions. This old committee was to become a forum for representatives of the medical staff to meet the governors to discuss points of mutual interest. Theoretically this would allow the governors to become conversant with the internal workings of the hospital and the doctors to come into 'contact with the governors'.<sup>155</sup> Though all the medical staff's other demands had been met, the situation could not be resolved while Burt remained. In protest Habershon and Cooper Foster, the senior medical officers and the doctors' representatives, refused to serve on the committee. Both sides were locked in a stalemate.

The publication of the report provided the first real indication outside the medical press of events within the hospital. *The Times* considered the report 'most conciliatory in tone towards the medical staff', but wrongly believed that it was 'likely to restore harmony in the institution'.<sup>156</sup> The dispute, which continued to drag on for another four months, now came under the spotlight of public opinion, making the governors more defensive. With this stalemate a contradictory position developed. The doctors worked with the new nursing system and even collected £2,500 to help the governors in their financial struggles, but there was no growth in cooperation.<sup>157</sup> The medical staff were not in an ideal position. The hospital, for all its apparent problems, held obvious financial and clinical benefits for its staff. Any opposition that went beyond a verbal confrontation would damage individual reputations and practices.

It was an independent body that finally forced the issue. The St.Saviour's Board of Guardians took an interest in the crisis, partly because the hospital supplemented the Board's own meagre medical services. In an attempt to resolve the dispute the Board issued a memorandum to the governors that took the medical staff's line. This stance is hardly surprising as the only information available to the guardians was from the doctors'

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<sup>155</sup> Guy's Archive, Subcommittee Report, A233/1.

<sup>156</sup> *Times*, 21 July 1880, 8.

<sup>157</sup> *BMJ*, 1 (1880), 784.

own statements to the press. The governors did not react favourably to this intervention, especially as they felt that the memorandum contained several accusations that could not go publicly unanswered. They seized the initiative and for the second time used the public forum to express their ideas. A member of the governing body officially defended the need for reform and claimed that they had 'endeavoured to comply with the wishes of the medical staff...'. The governors claimed that their acts of conciliation had been met with

...renewed acts of opposition either in the form of collective protests or of attacks in public journals, and by the peremptory demand for the dismissal (as the only condition of peace) of an officer whose intentions and acts the staff, in the opinion of the governors, wholly misapprehend.

They closed their statement with a warning that it was they who administered the hospital under an Act of Parliament and that it might become necessary to take action against the staff if the 'struggles for power' continued.<sup>158</sup> The doctors responded clumsily. Habershon and Cooper Foster protested on their behalf. Their protest carried an allegation which the governors interpreted as an accusation of deliberate mismanagement. As Habershon and Cooper Foster refused to withdraw their statement 'unreservedly' they were asked to resign. The real moment of crisis had come and the doctors' resolution and solidarity collapsed. The governors' request for Habershon's and Cooper Foster's resignation was a calculated step to frighten the staff into subservience by showing that they were prepared to take the consequences of mass resignation. Self-interest appeared to override professional grievances, though with intense competition for hospital posts the doctors were probably aware that their resignations would only have a temporary impact. The remaining staff withdrew the offending letter and reluctantly agreed to serve on the taking-in committee.

The medical community was disappointed. The *BMJ* noted that the governors had triumphed because the doctors had failed to find unanimity at the crucial moment:

the governors have... virtually told the medical staff that the nursing arrangements are no business of theirs; they have not very obscurely

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<sup>158</sup> Guy's Archive, General Court, A1/3.

intimated that the medical staff must consider themselves as merely occupying a servile position, and that if they object to the matron, they must go, not the matron.<sup>159</sup>

Even *The Times* recognised that the doctors had thrown away their unassailable right to influence ‘by injudicious letter-writing’.<sup>160</sup> The dispute which had lasted for ten months now trailed to an end. The press lost interest, and although Habershon and Cooper Foster were greeted as martyrs, their resignations had little impact on the internal affairs of the hospital.<sup>161</sup>

Pavy, writing to the *Lancet*, felt that something had been achieved as ‘we began with no recognised status in relation to the nursing administration, and we leave off with an official position upon a committee of governors’.<sup>162</sup> The *Lancet* itself was not as optimistic, seeing the taking-in committee as ‘a half-hearted and round about way of making a concession’; a compromise that ‘cripples while it degrades’.<sup>163</sup> Pavy’s view was to prove more accurate. By November 1880 it appeared that ‘the committee of governors, in their recent relations with the staff, have shown a disposition to retrace their former position of hostility, and have entered upon a course of deference to the opinions of the physicians and surgeons of the hospital’.<sup>164</sup> Within months the taking-in committee had started to take a prominent role in the hospital’s administration. This in effect put the medical staff at Guy’s in a stronger administrative position than many of their other colleagues in general hospitals.

When the new nursing arrangements were published in March 1881, all sides claimed victory. The governors secured their nursing reforms and the nurses were placed under the medical staff’s authority. Burt no longer proved a problem. She was stripped of her title of lady-superintendent and resigned the following year, not under pressure

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<sup>159</sup> *BMJ*, 2 (1880), 593.

<sup>160</sup> *Times*, 18 October 1880, 9.

<sup>161</sup> Guy’s Archive, General Court, A1/3.

<sup>162</sup> *Lancet*, 2 (1880), 714.

<sup>163</sup> *Lancet*, 2 (1880), 624; 662.

<sup>164</sup> *BMJ*, 2 (1880), 862.

from her critics, but to marry. The *BMJ* claimed that the main points at issue during the dispute 'are virtually decided in favour of the medical men'.<sup>165</sup> Not all were as enthusiastic: the *Medical Times & Gazette* noted that authority over the nurses continued to rest with the treasurer, superintendent and matron rather than the taking-in committee.<sup>166</sup> The doctors, left in a better position than when the dispute had started, raised no objections. Informal administrative repercussions followed. During the crisis the medical staff had convened hasty meetings at Habershon's house to formulate their attacks. Between 21 November 1879 and 10 October 1880 there were no less than 29 unofficial meetings.<sup>167</sup> The habit of meeting to discuss matters relevant to the medical staff had been established and it was continued in a more formal manner once the dispute had ended. By November the governors had accepted the Medical Committee as part of the hospital's administration and it worked in tandem with the taking-in committee.

The events at Guy's were only extraordinary for the public attention they attracted. During 1880 all eyes seemed to turn to Guy's and the issues of medical authority and representation were openly discussed. The dispute, however, was not entirely unique and symbolised the conflict that evolved between doctors and governors in many hospitals and the way increased formal influence was obtained through stubbornness, apparent defeat and compromise from which the doctors emerged with a stronger administrative position.

## 6. DOCTORS AND HOSPITAL MANAGEMENT

The *Lancet*'s call that 'medical authority must be supreme in a medical charity' was never practical in the nineteenth century.<sup>168</sup> It foundered on the hospitals' voluntary nature and the governors' important financial role. However, the 'want of union and mutual acquaintance' that the *BMJ* had suggested existed between doctors and governors in the

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<sup>165</sup> *BMJ*, 2 (1881), 438.

<sup>166</sup> *Medical Times & Gazette*, 1 (1881), 403.

<sup>167</sup> H.C.Cameron, *Mr Guy's Hospital 1726-1948* (1954), 212.

<sup>168</sup> *Lancet*, 1 (1881), 107.

late 1870s, had been modified by the 1890s.<sup>169</sup> Where this was true of London, it also applied to other provincial hospitals.<sup>170</sup>

The doctor-governor relationship evolved through tension and conflict, and over time. Conflict was required to produce an extension of formal authority, but developments in medical science and a change in the nature of the hospital promoted administrative change. For St.Bartholomew's, 1868/9 marked a watershed. A retrospective view of the hospital's administration shows that from 1868 the doctors' passive position was gradually modified and replaced with a series of medically inspired subcommittees and recommendations.<sup>171</sup> Changes of this type are difficult to explain. Medical journals and hospital reformers did help to create an environment in which medical representation became a professional goal. Doctors working in the capital's hospitals were undoubtedly influenced by such ideas, but the internal politics of individual hospitals played an important role. An increase in medical authority might be linked to an altered perception of medical science. Governors, as part of a wealthy London business and social elite, met doctors through the hospital and in private practice and were influenced by society's altering perceptions of medicine and medical practitioners.<sup>172</sup> However, at the centre of these changes was the governors' view of their own medical staff. At St.Bartholomew's, the extension of the doctors' influence was closely connected with attacks on the hospital's administration in 1868/9. In response, the governors 'requested' the doctors to provide a medical defence of the hospital, giving the medical staff a lever through which they could start to assert their influence.<sup>173</sup>

The London's experiences from the late 1870s clearly show how an alteration in the governors' approach to the hospital required both a formal and informal extension of

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<sup>169</sup> *BMJ*, 2 (1878), 962.

<sup>170</sup> H.Marland, 'Lay and Medical Conceptions of Medical Charity during the Nineteenth Century' in J.Barry & C.Jones (eds.), *Medicine and Charity Before the Welfare State* (1994), 166.

<sup>171</sup> SBH Archive, Medical Committee, Mc/1/1.

<sup>172</sup> See M.Brightfield, 'The Medical Profession in Early Victorian England', *Bulletin of the History of Medicine*, 35 (1961).

<sup>173</sup> SBH Archive, Governors' Minutes, Ha/1/23.



medical authority. An agreement over the finances of the medical college in 1876 allowed greater formal cooperation, acting as a catalyst in the hospital's administration.<sup>174</sup> The doctors gave up their sole authority over the medical college, but acquired a formal position in the London's administration.<sup>175</sup> From the 1880s onwards, the House Committee became more closely involved in the medical administration of the hospital through its link with the medical college. The governors were now being faced with issues that were beyond their business experience and in response they increasingly referred medical issues to the Medical Council for a decision and invited them to take part in special subcommittees.<sup>176</sup> Sydney Holland could still put forward his own scheme for reorganising the administration of anaesthetics in 1896, but the doctors had been instrumental in proposing plans for the improvement of the hospital's sanitary system in 1890 after outbreaks of typhoid, and had been actively consulted over the administration of the outpatients' department in 1890.<sup>177</sup>

Authority, however, was rarely one sided. Even the most secure medical staff at the specialist hospitals still had to negotiate their demands and the governors' decision was always final. However, by the end of the nineteenth century the medical staff of London's hospitals had entered a loose partnership with the governors. Changes in medical science and the public's perception of the medical profession and the value of institutional treatment helped modify the doctors' position in society and within the hospital. The medicalisation and the inclusion of new practices based on medical science into the hospital environment increasingly forced governors to consult their medical staff. In specialist hospitals this transformation occurred from the hospital's foundation because their specialist nature demanded a greater level of medical involvement, but even at the endowed hospitals changes were taking place.

Doctors had never been entirely excluded from hospital management, but from the 1850s onwards they were able to extend their informal and formal authority. Not all

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<sup>174</sup> See pages 154-5.

<sup>175</sup> LH Archive, Subcommittees, A/9/121-2.

<sup>176</sup> LH Archive, College Council, LM/A/1/1.

<sup>177</sup> LH Archive, Subcommittee, A/9/122.

institutions progressed at the same rate and by the end of the Victorian period some doctors were still struggling to get their voices heard. Conflict, tension and an alteration in the nature of the hospital all conspired to increase the level of medical influence. An increase in informal authority was gradual and aroused little opposition, partly because the governors could feel that they dictated the agenda. The direct inclusion of the medical staff in the hospital's management was a different issue and one where conflict seemed inherent. The medical profession and hospital reformers were not arguing for complete medical control. They recognised the hospitals' voluntary nature and sought to uphold it. Separate spheres were established in which the doctors made no attempt to encroach on the governors' financial control. What they wanted was a joint administration in which doctors could use their professional status and knowledge to help manage the hospital on medical lines. Increasingly, governors were being forced to modify their conservative approach to hospital management. However, if control over the working environment is an indication of professionalisation, then the medical profession in London's hospitals was only at the start of the process by the start of the twentieth century.

Voluntarism remained the key ethic of the hospital and even doctors begrudgingly gave their services without charge. Science and professionalism were insufficient to counter an authority based on charitable contributions and tradition. The result was a modification of the governors' power, often at their behest, to promote more efficient management. Doctors were left in a better position with more influence, but they still had to negotiate their recommendations and modify their demands to the financial constraints of the voluntary system and the hospitals' philanthropic basis.

## **Part III: An Institutional Comparison**

## The Whitechapel Union.

Hospitals presented only one part of the network of healthcare services available to the sick poor. In the hospital the emphasis was on deserving cases; private medical care was for those who could afford to pay a doctor's fee. The medical profession did provide free medical care or treatment at a reduced rate to the sick poor, but it was the state through the Poor Law that provided care for all those excluded from the hospital. Hospitals and Poor-law infirmaries offered an institutional environment for healthcare, but did infirmaries experience similar changes as their voluntary counterparts? Was the process of diversification and dilution consequences of institutional healthcare, or were they experiences unique to the voluntary sector? The aim of this section, therefore, is to develop the analysis applied to the London hospitals and apply it to a metropolitan Poor-law union.

Historians of the New Poor Law have focused on the plight of those admitted to the workhouse, modifying Dickensian images, or explained development in terms of the changing conceptions of poverty and social policy.<sup>1</sup> Analysis has consequently overlooked the financial underpinning of the very institution they seek to explain. Financial concerns were central to the Poor Law, but most studies of financial policy focus on expenditure, and income is only considered in the context of the poor rate.<sup>2</sup> This emphasis was reflected within the Poor Law, especially at a national level. As an institution the Poor Law was a response to concerns over spending; a reaction against the perceived financial extravagance and irresponsibility of the old administration, evolving around the mistaken

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<sup>1</sup> See D.Roberts, 'How Cruel was the Victorian Poor Law?', *Historical Journal*, 6 (1963); N.Longmate, *The Workhouse* (1974) or M.A.Crowther, *The Workhouse System 1834-1929* (1983) who provides a more analytical study. D.Roberts, *The Victorian Origins of the British Welfare State* (1960) and R.G.Hodgkinson, *The Origins of the National Health Service* (Cambridge, 1967) are among those who discuss the New Poor Law as an antecedent of the welfare state.

<sup>2</sup> P.Wood, 'Finance and the Urban Poor Law' in M.E.Rose (ed.), *The Poor and the City: The English Poor Law in its Urban Context 1834-1914* (Leicester, 1985), provides one of the only studies which looks at Poor-law finance, but the bias is heavily towards expenditure.

belief that economy was related to efficiency. Reform did not have a long-term effect; after an initial decline expenditure resumed its upward momentum, rising dramatically during the 1860s.<sup>3</sup> Income and expenditure were interlinked. Initially resources frustrated the administrators' exertions to implement the principles of 1834. However, after 1850 modifications in the Poor Law's financial base allowed expenditure to develop, working with public opinion and changing notions of relief to favour the sick, the young, and the aged, groups that were initially classified as the non-problematic poor. Consequently a more liberal institution evolved, but one that retained a deterrent base. It is a process exemplified by the Whitechapel Union.

## 1. FINANCING THE UNION

The reconstruction of the Whitechapel Union's income between 1850 and 1898 is a formidable task. With the emphasis on expenditure, references to income are paltry and inconsistent. When hospital reformers lamented the structure of hospital accounts, they were perhaps unaware of the complexity of Poor Law finance. The belief in the sanctity of local government complicated the method of accounting, creating idiosyncratic local procedures. No systematic structure existed before 1879 when the Poor Law Board introduced a uniform system of accounts, forcing unions to present biannual financial statements. Before 1879 it is essentially a matter of piecing together what little information remains; separating income from expenditure, a process complicated by the fact that for the Whitechapel Union only the 1863-5 general ledger has survived.

The scale of finance, even for a small union, made the hospitals' resources seem inadequate. In 1863/4 the Whitechapel Union's income was £71,144 2s 3d; even by 1895 a large teaching hospital like University College Hospital only had an income of £20,722 8s 3d and the endowed income at St.Bartholomew's only reached a comparable amount after 1880.<sup>4</sup> The Whitechapel Union was not even a wealthy district and had a low

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<sup>3</sup> Wood, 'Finance and the Urban Poor Law', 22.

<sup>4</sup> Whitechapel Union, Greater London Records Office (Whitechapel Archive), General Ledger, Wh/145/1; UCH 1895 Annual Report 1895; SBH Archive, General Account Books, Hb/23/4.

rateable value in comparison to unions in the West End.<sup>5</sup> It must be remembered, however, that no income was explicitly set aside for medical provision. Healthcare funding was provided out of the union's total resources and had to compete with the financial demands of the unions other functions.

Whereas the London hospitals had been founded on philanthropy, the basic unit of finance for the New Poor Law was the poor rate, and until the alteration of the pattern of borrowing in the 1860s it set the boundaries of relief. It was not exclusively a rate for the maintenance of the poor, but the foundation of local government finance.<sup>6</sup> The rate was based on real property values, not the expanding wealth of industry and commerce, generating concern that the existing method of administration was incapable of tapping these resources. Certainly parishes like St.Katherine's, Whitechapel, which had few residents, relied on the overcrowded surrounding districts to supply the dock with labour and relieve the poor in times of distress. Inequitable distribution was compounded by obsolete or partial valuations. The absence of professional valuers and an uneven pattern of urban development ensured that the poor rate did not always reflect economic reality. To overcome the problems involved with assessing property with a low rateable value, the 1850 Small Tenements Act allowed parishes to assess the owners, instead of the occupants, of all tenements with a yearly rateable value exceeding £6. However, poorer parishes undervalued property to reduce the burden, repeatedly ignoring the homes of the poor.<sup>7</sup> It was only in 1862 that the Union Assessment Committee Act permitted more realistic assessments by transferring valuation from the parish to Boards of Guardians, the unions' main administrative body. Problems, however, persisted. In 1891 the London County Council's (LCC) Valuers' Department revealed that one third of London was under-assessed, amounting to £900,000 in lost income.<sup>8</sup>

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<sup>5</sup> SC on Poor Law Relief, *PP* 1888 XV, 522.

<sup>6</sup> See D.Owen, *The Government of Victorian London 1855-1889: The Metropolitan Board of Works, the Vestries and the City Corporation* (1982).

<sup>7</sup> J.Roebuck, *Urban Development in Nineteenth Century London* (1979), 30-1.

<sup>8</sup> A.Offer, *Property and Politics 1870-1914: Landlords, Law, Ideology and Urban Development in England* (Cambridge, 1981), 193.

Finance was therefore often inelastic and inequitable, oblivious to periods of industrial distress, and hostage to the ratepayers' latent abhorrence of increased expenditure.<sup>9</sup> The rate lacked philanthropy's flexibility and the whole system rested on the honesty and efficiency of the overseers who collected the rate. Unlike the collectors employed by hospital governors, overseers were widely renowned for their corruption and the system was hampered by clerical inaccuracies.<sup>10</sup> Corruption, however, was not apparent in the Whitechapel Union, partly because the parish overseers were assisted by the 68 trustees of the 1853 Whitechapel Improvement Act. Collectors in Whitechapel seemed anxious to ensure that the poor rate was paid in full as they worked on commission, while the Metropolitan Management Act imposed heavy penalties for a lax performance.<sup>11</sup> They had an interest in maximising returns and therefore the Union's income.

Individual services under the New Poor Law were not budgeted for, and the parishes covered by the Whitechapel Union were charged according to their retrospective expenditure. In a system of finance where 'poverty rather than wealth' dominated, development progressed at the rate the poorest parish could afford.<sup>12</sup> This inequality was transferred to the ratepayers. As a regressive tax, the rate fell mainly on the shoulders of the working classes. A resident in the affluent West End might contribute 1% of his income to municipal purposes; the poor person in the East End anything up to 6%.<sup>13</sup> In 1861 *The Times* alleged that poor ratepayers had been forced to pawn their goods or were driven to suicide under the burden of the rates, but such stories are hard to believe, a

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<sup>9</sup> Concerns over spending, inflamed by the threat posed by the Progressive Party, a combination of New Liberals and Fabians which came to dominate the LCC in the 1890s, was reflected in the formation of the London Ratepayers' Defence League in 1894. It was an off-shoot of the Liberty and Property Defence League to oppose high spending and taxation on ground values: H.Perkin, *The Rise of Professional Society: England Since 1880* (Princeton, 1989), 138.

<sup>10</sup> J.Longbottom, 'The Collection of Rates' in *Poor Law Conference Reports, Yorkshire District* (1880), 200-4.

<sup>11</sup> Roebuck, *Urban Development*, 56.

<sup>12</sup> Cited in Wood, 'Finance and the Urban Poor Law', 26.

<sup>13</sup> Owen, *Government of Victorian London*, 165.

feeling shared by the Poor Law Board.<sup>14</sup> Poor ratepayers, however, did display a reluctance to pay the rate and few paid punctually, reflecting an inability to pay.<sup>15</sup> Consequently income was not always as forthcoming as the guardians hoped because the weight of relief fell on those districts and social groups least able to pay. Guardians were therefore hesitant to exert undue pressure on their ratepayers, which in turn slowed development. Numerous references are made in the Whitechapel Union's minutes to demands for contributions, and to protect the Union's income the guardians resisted the 1884 Summary Jurisdiction (Repeal) Bill because it threatened to remove their powers of enforcement. The LCC was later to experience a similar problem.<sup>16</sup> Non-payment at a parish level created problems for the Whitechapel Union and in 1854 the existence of several outstanding amounts forced the guardians to negotiate an overdraft.<sup>17</sup> A parish's reluctance to contribute often disguised opposition to the level of expenditure and concerns over the unfair distribution of the rate burden. Gylms, vestry clerk to St.Katherine's Precinct, wrote in 1860 that 'it really seems monstrous that a small precinct like [St.Katherine's] with only 6 paupers or thereabouts exclusive of lunatics should be paying £600'.<sup>18</sup> Christchurch expressed similar concerns in the following year, calling for a Poor Law Board inquiry into the 'heavy claims made upon this parish by this board'.<sup>19</sup> Neither body had any success.

Pressure to resolve the problems of inequitable distribution was partly answered by the 1865 Union Chargeability Act. The 1861 Irremovable Poor Act had extended the number eligible for relief and when combined with an increase in the numbers relieved, a situation was produced that threatened to bankrupt the metropolitan Poor Law. A solution was needed to release property resources. As the landed interest had moderated

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<sup>14</sup> M.Caplan, 'The New Poor Law and the Struggle of Union Chargeability', *International Review of Social History*, 23 (1978), 283.

<sup>15</sup> M.E.Rose, *The English Poor Law* (Newton Abbot, 1971), 218.

<sup>16</sup> LCC papers, Greater London Records Office (hereafter LCC Archive), Finance Committee 1889-1898, MIN/5013.

<sup>17</sup> Whitechapel Archive, Guardians' Minutes, Wh/13.

<sup>18</sup> Whitechapel Archive, Correspondence, Wh/107/12.

<sup>19</sup> Whitechapel Archive, Guardians' Minutes, Wh/31.



its harsh attitude, reflecting the decline of its position in parliament and reliance on landed income, it became possible to restructure the rating system. Under the 1865 Act local relief expenditure was transferred from the individual parish to a central common fund, creating 'a real administrative community instead of a loose amalgamation of quarrelling member states'.<sup>20</sup> Assessment shifted from poverty to property. Caplan believes that the Act was a 'milestone on the road to social justice'; 'a sort of revolution' in the parochial rating system that had not been touched since the Elizabethan period.<sup>21</sup> The Poor Law acquired a redistributive element, but the Act left many problems unresolved.

The 1865 Act could do nothing to reconcile the discrepancies between localism and functional reality. Paupers did not necessarily take notice of administrative boundaries and with a relaxation of the settlement laws the Whitechapel Union found itself relieving other districts' paupers.<sup>22</sup> Financial this was intolerable. To relieve the burden on their own finances, guardians charged relief to the pauper's nominal union of settlement, creating a pre-cursor to the NHS's internal market. Amounts were not fixed, but pursued with energy as it reduced local expenditure. In the case of Irish paupers, where removal was not always possible and repayment harder to obtain, difficulties were encountered. The Whitechapel Union was reluctant to offer relief and opposed clauses in the 1880 Poor Removal Bill that tried to withdraw the Irish from the settlement laws.<sup>23</sup> However, from 1881 this item of income diminished as 'consent' agreements were signed with other unions, the first with St.George's-in-the-East. The guardians had apparently decided that it was easier to relieve other districts' paupers and receive reciprocal rights than charge the pauper's union of settlement.<sup>24</sup>

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<sup>20</sup> M.E.Rose, 'The Crisis of Poor Relief in England 1860-1890' in W.J.Mommsen (ed.), *The Emergence of the Welfare State in Britain and Germany* (1981), 59.

<sup>21</sup> Caplan, 'Struggle for Union Chargeability', 285, 299 and 296-9.

<sup>22</sup> M.E.Rose, 'Settlement, Removal and the New Poor Law' in D.Fraser (ed.), *The New Poor Law in the Nineteenth Century* (1976), 25-44.

<sup>23</sup> Whitechapel Archive, Guardians' Minutes, Wh/63.

<sup>24</sup> Whitechapel Archive, Guardians' Minutes, Wh/64.

Thane concludes that 'the poor rate... continued to be the guardians' only source of income', redistributing costs on the basis of relief.<sup>25</sup> Certainly for London this does not hold true. Where hospitals could not be funded by direct philanthropy alone, Poor-law unions did not depend entirely on the poor rate. Poor-law finance was inherently diverse, though with only 30% of the income drawn from outside the poor rate between 1890 and 1895, diversity did not match the hospitals' financial experiences.

From the 1860s onwards the relaxed climate of borrowing encouraged by the 1867 Metropolitan Poor Law Act increased the income available to individual unions. Borrowing had always been an important source of funding, but in the 1860s the existing loans from the Public Works Loans Board were extended from twenty to thirty years and credit restrictions were relaxed, allowing additional borrowing without an increased burden on the rate. From 1864/5 to 1870/1 the total authorised for borrowing in England and Wales rose from £6.95 million to £8.4 million.<sup>26</sup> Hospitals used loans to meet expansion and to solve periodic financial problems, but in the Poor Law, and in the metropolitan unions in particular, these loans were directed to improving specialist services.<sup>27</sup> The Whitechapel Union borrowed £8,000 in 1870 to extend the South Grove Workhouse, and a further £2,600 in 1876 to pay for part of the expense of the conversion of the Baker's Row workhouse into an infirmary.<sup>28</sup> The major insurance companies responded to this change and lent heavily to local unions since they represented a safe and profitable market.<sup>29</sup> The Whitechapel Union negotiated its borrowing requirements with the Metropolitan Life Assurance Society and the London Life Association, generally at 4% secured on the poor rate. Repayment was slow and costly. Loans provided an immediate source of capital and a drain on resources. Interest in 1864 amounted to £1,249 12s 10d,

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<sup>25</sup> P.Thane, 'Women and the Poor Law', *History Workshop Journal*, 6 (1978), 40.

<sup>26</sup> Wood, 'Finance and the Urban Poor Law', 38.

<sup>27</sup> See G.Ayers, *England's First State Hospitals and the Metropolitan Asylums Board* (1971), for the expansion of the MAB and the associated services.

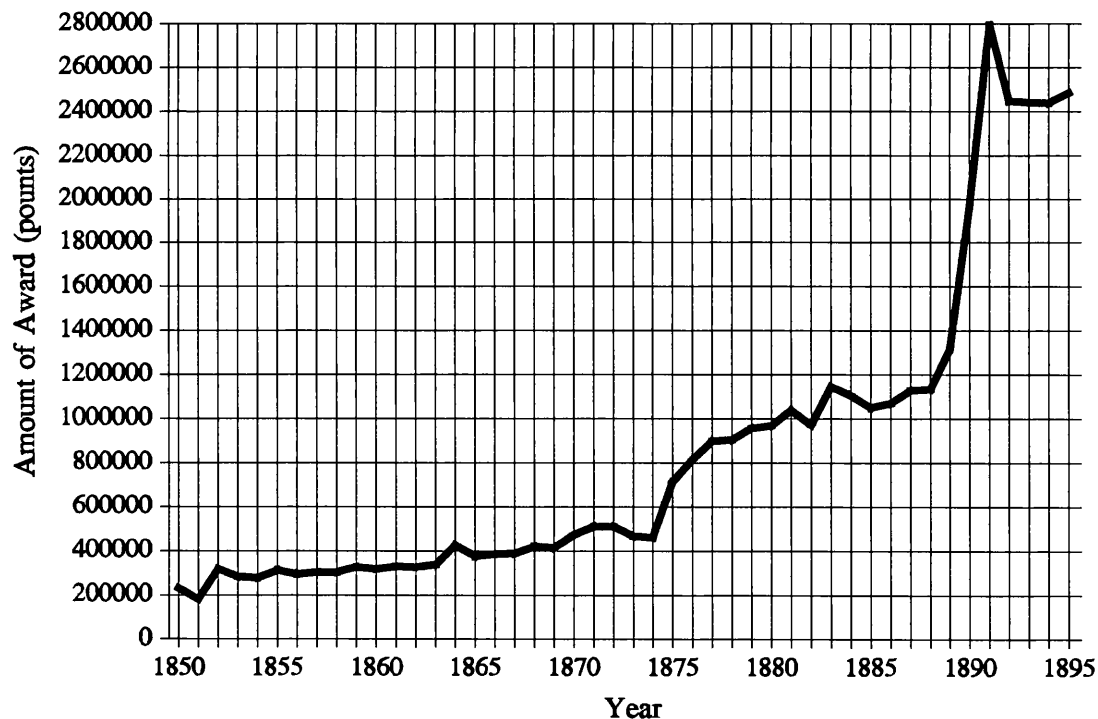
<sup>28</sup> Whitechapel Archive, Loan Account, Wh/143.

<sup>29</sup> H.A.L.Cockerall & E.Green, *The British Insurance Business 1547-1970* (1976), 70.

increasing the total debt to £28,298 18s 11d.<sup>30</sup> Efforts were made to place loans on deposit until the money was needed, but the resultant income was insufficient to cover the interest on the original loan. However, loans were indispensable. The programmes of capital expansion, which steadily became an inherent feature of the metropolitan Poor Law as attitudes to relief changed, could not be provided out of the sensitive poor rate, so unions had to borrow. The more grandiose the schemes, the larger the amounts, though the union's ability to repay loans imposed a limit on the amount that could be borrowed.

Central government, aware that the poor rate and loans were insufficient to meet union expenditure, allocated a certain proportion of national taxation through grants-in-aid to provide additional funds.

Figure 7.1: Receipts-in-Aid: National Awards (1850-1897)



Source: LGB Reports 1850-1897.

<sup>30</sup> Whitechapel Archive, General Ledger, Wh/145/1.

Introduced in 1846 as part of Peel's Corn Law repeal package and voted annually by parliament, grants-in-aid were sweeteners to the agricultural interest to compensate for the withdrawal of protective tariffs by defraying some of the Poor-law's administrative costs. The effect went beyond agriculture and created a stable source of income that involved no local financial responsibility. In 1859 the Whitechapel Union received £805 13s 4d in grants, to cover part of the schoolmasters' and medical officers' salaries.<sup>31</sup> From 1874 there was a dramatic increase in grants when the Local Government Board attempted to use them to increase indoor relief (see below). By 1876 £556 17s 7d was awarded to cover the medical officers' salaries, and a further £1,359 4s for the care of lunatics and registration of births and deaths.<sup>32</sup> The intention was to bribe local authorities to overcome their natural reluctance to spend money, a position the Liberal Party opposed in the belief that grants were disguised 'doles', encouraging local extravagance and maladministration.<sup>33</sup> As demands on the exchequer multiplied, central departments expanded under the burden of routine inspection and administration and pressure grew to extend national sources of revenue. Hodgkinson argues that grants-in-aid had little immediate effect in improving medical services as intended, but grants did materially reduce the rates, founding a practice of central government intervention to establish additional services and provide a minimum level of efficiency.<sup>34</sup> They provided more than a simple top-up to the income raised by the poor rate.

Additional, sundry items also contributed to the Union's income, but in the Poor Law their importance was marginal in comparison to the level of non-charitable funding in hospitals. Similar resources, however, were used. Mostly these were derived from the sale of investments or property. The central board expected guardians to use the income generated from this source to reduce any outstanding debts. In the Whitechapel Union the guardians did sell 'property', like the £788 1s 1d in bank annuities from the Mile End New Town vestry in 1858 with this intention in mind, rather than as a solution to an

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<sup>31</sup> Whitechapel Archive, Guardians' Minutes, Wh/23.

<sup>32</sup> Whitechapel Archive, Guardians' Minutes, Wh/58.

<sup>33</sup> Offer, *Property and Politics*, 165.

<sup>34</sup> Hodgkinson, *Origins of the National Health Service*, 344-51.

impending financial crisis.<sup>35</sup> However, they shared a general dislike of the central authority's often heavy-handed and curt demands in forcing sales. More marginal amounts were derived from the services the Union provided and consequently the central board did not attach much importance to them. Under the New Poor Law workhouse inmates were expected to perform a task of work, and local unions sold any proceeds from it, as well as their old uniforms. Nothing was wasted and paupers were not even safe after death: ten shillings were taken from a 'deceased pauper' in 1864 and applied to the general fund. Other more regular pecuniary benefits were derived from the workhouse itself. The site of the old workhouse was initially rented in 1863 and Mr Ilsley was given £9 15s for collecting the rent. During the building of the South Grove workhouse the building was let for six months to the North Surrey School District for £300 as a place to treat their children suffering from ophthalmia.<sup>36</sup>

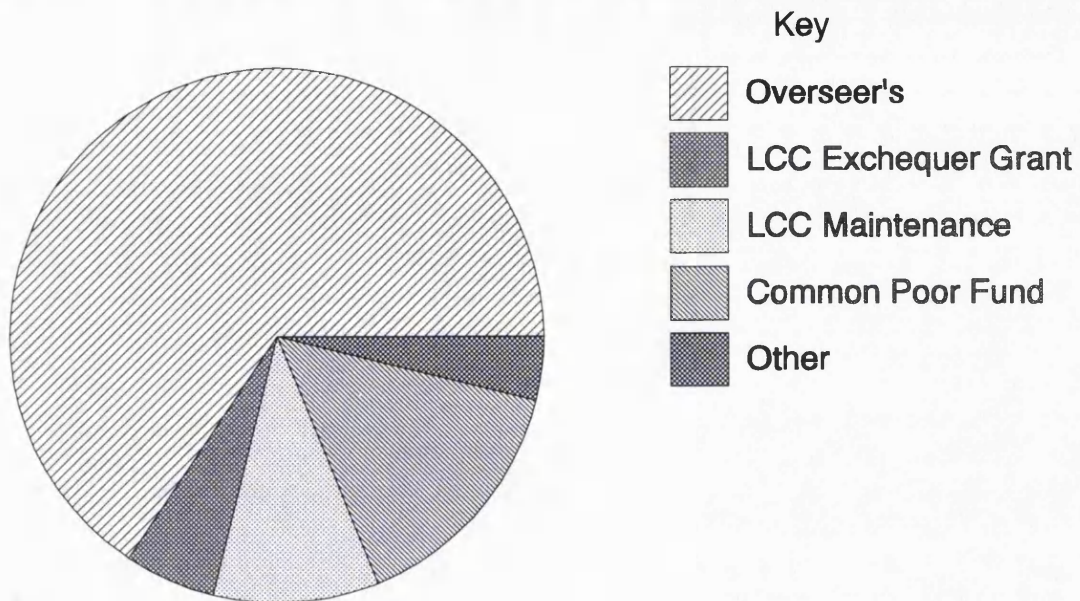
By 1890 the composition of income is easier to discern. From the biannual financial statements produced after 1879 the relative proportions of income can be reconstructed. Unfortunately only the financial statements for the period 1890 to 1895 have survived. Grievances over rating from the 1860s onwards had resulted in a series of piecemeal concessions that were reflected in the structure of finance. The rateable unit of the metropolitan Poor Law was extended, certain kinds of expenditure were combined in a common fund and distributed at a metropolitan level, and government grants were increased. The structure of income remained biased in favour of the poor rate (overseers), but the diversification already present in the 1860s had escalated.

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<sup>35</sup> Whitechapel Archive, Guardians' Minutes, Wh/23.

<sup>36</sup> Whitechapel Archive, Guardians' Minutes, Wh/55.

Figure 7.2: Income (main) 1890-1895.



Source: Whitechapel Archive, Financial Statement, Wh/142/1.

Loans continued to provide for capital expansion. The Treasury regarded local borrowing as a threat to national credit and pursued a strategy to protect the Exchequer from local demands, while the Local Government Board pressed for easy terms to safeguard their programme of expansion.<sup>37</sup> The formation of the LCC in 1888 extended credit facilities to the local authorities, partly overcoming the tension between the Treasury and the Local Government Board in favour of the latter's objectives.<sup>38</sup> Unions received nearly half the LCC's loans, but the expansion of Poor-law services meant more had to be borrowed:

<sup>37</sup> C.Bellamy, *Administering Central-Local Government Relations 1871-1919* (Manchester, 1988), 79.

<sup>38</sup> P.Ryan, 'Politics and Relief: East London Unions in the Late Nineteenth and Early Twentieth Centuries' in M.E.Rose (ed.), *The Poor and the City: the English Poor Law in its Urban Context 1834-1914* (Leicester, 1985), 151.

Table 7.1: Whitechapel Union's Borrowing, 1891-1898.

Year	Amount owed	Amount repaid
1890/1	£24,971 18s	£1,727 4s 1d
1891/2	£23,244 13s 11d	£1,789 19s 7d
1892/3	£21,454 14s 4d	£1,915 13s 7d
1893/4	£20,739 0s 9d	£2,464 10s
1894/5	£32,274 10s 9d	£3,050 12s 6d
1895/6	£43,673 18s 3d	£3,220 4s 3d
1896/7	£40,453 14s	£3,399 7s 8d
1897/8	£39,554 6s 4d	£3,482 6s 10d

Source: Whitechapel Archive, Loan Account, Wh/143.

After 1898-9, when credit was restricted by high interest rates and the government's own demands increased, borrowing was restricted. This led to renewed demand for further grants and generated friction between local and central government at a time when their economic relationship was being questioned and the nature of local funding was under debate.<sup>39</sup>

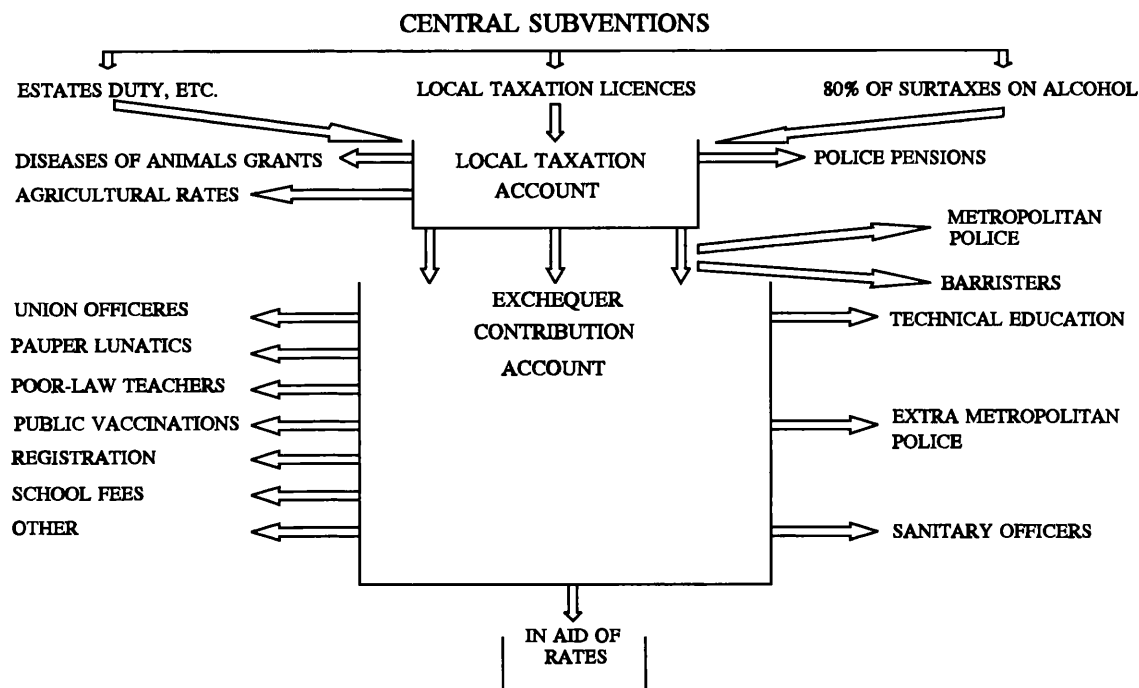
The old grants-in-aid system had been succeeded by contributions from the LCC in the form of assigned revenues, redistributing local taxation (LCC Maintenance) and government grants (LCC Exchequer) from the Local Taxation Account. Reorganisation had been discussed in 1871, but it was not until 1888 that the Liberal Party was willing to consider new proposals to aid the rates and solve the problem of the claims on national taxation arising from increases in local authority expenditure. It was hoped that by assigning revenue local demands on national taxation would be 'choked-off'.<sup>40</sup> Under the 1888 Local Government Act local authorities were allocated certain excise taxes and licence duties in the same proportion as they were collected locally to replace the

<sup>39</sup> J.Harris, *Unemployment and Politics: A Study in English Social Policy 1886-1914* (Oxford, 1972), Appendix A; Offer, *Property and Politics*, 283-313.

<sup>40</sup> G.Baugh, 'Government Grants-in-Aid of the Rates in England and Wales 1889-1990', *Historical Research*, 65 (1992), 218.

profusion of central government grants (amounting to £2.8 million per annum). In addition 40% of the probate fees were allocated.

## Structure of Income Contributing to Assigned Revenue



Source: J.Watson Grice, *National and Local Finance* (1910), 97.

By including probate the Conservatives' aim of taxing personalty as well as land was partially conceded.<sup>41</sup> Goschen, as Liberal Unionist Chancellor had originally suggested in 1886 that these 'assigned' revenues should be linked to indoor pauperism, but this was abandoned under pressure from representatives of rural areas that had low indoor but high outdoor pauperism.<sup>42</sup> Even with the London Conservatives' rearguard action in defence of the principles of 1834 based on London's special needs, Goschen was forced to adopt

<sup>41</sup> Offer, *Property and Politics*, 201-2.

<sup>42</sup> Bellamy, *Administering Central-Local Government Relations*, 33.



a creed that he felt to be indefensible. Probate allocation was fixed at the same proportion as the total grants-in-aid received by the authorities in 1887/8, linked to numbers relieved and expenditure. Setting the revenues at the 1888 level proved insufficiently elastic to keep pace with local spending and the hope of limitation was defeated. The Treasury admitted that the system was 'obsolete and inequitable'.<sup>43</sup>

Once problems over the financial responsibility for pauper lunatics were solved the new system went smoothly into operation.<sup>44</sup> Subsidies rose with prosperity, doubling nationally in five years from £4 million in 1887 to £8 million in 1892. Subsidies covered the payment of Poor-law teachers; school fees for pauper children sent to district schools; registration; maintenance of lunatics; medical officers' salaries and medical expenses; and grants against outdoor relief. Over the five year period contributions to the Whitechapel Union amounted to 5.5% for outdoor relief and 10% for indoor relief, meeting £1,153 9s 16d of the Union's medical expenditure in 1894/5 alone.<sup>45</sup> As local rating resources did not always correlate with local needs, in effect this was reimbursing the Union for the development of central services and at the same time stimulated their extension.

A new source of income was added to the existing structure of finance in 1867 under the Metropolitan Poor Act which established the Metropolitan Common Poor Fund. It was a concession to the poorer unions where demand out-stripped possible income given their economic and occupational structure. Through a central body the rate was partially redistributed from the wealthier unions who had fewer pressures on their facilities.<sup>46</sup> For MacKinnon, the Fund 'permitted poor unions to make their workhouses properly curative or deterrent largely at the expense of the richer unions'.<sup>47</sup> It reflected

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<sup>43</sup> E.P.Hennock, 'Finance and Politics in Urban Local Government in England 1835-1900', *Historical Journal*, 6 (1963), 224-5.

<sup>44</sup> LCC Archive, Finance Committee - Presented Papers, MIN/5145.

<sup>45</sup> Whitechapel Archive, Financial Statement, Wh/142/1.

<sup>46</sup> This was not always deemed to be fairly proportioned. The Whitechapel Union's protests to the MAB about 'inequality of assessment' in 1868 received widespread support amongst the metropolitan unions though little actual change: Whitechapel Archive, *Guardians' Minutes*, Wh/48.

<sup>47</sup> M.Mackinnon, 'English Poor Law Policy and the Crusade Against Outrelief', *Journal of Economic History*, 47 (1987), 612.

an awareness that some problems were of a metropolitan rather than of a purely local nature. A similar scheme had already been adopted under the temporary 1864 Metropolitan Houseless Poor Act, under which destitute wayfarers, wanderers and foundlings given shelter for the night could be charged to a central fund.<sup>48</sup> A precedent had been established and the provision was included in the new Act.

The Metropolitan Poor Act allowed unions to contribute towards the services of the MAB at an average of 4d. in the pound 'upon the Rateable value of property within the Metropolis', and then claim back expenditure from the Metropolitan Common Poor Fund. Not all items were accepted. The £1 5s spent by the guardians of the Whitechapel Union on the maintenance of boys sent to the Seamen's Hospital at Greenwich in 1874 was disallowed, but generally the Union received over twice as much as it contributed.<sup>49</sup> Only from 1870 was this extended to include the indoor poor at a fixed rate of 5d. per pauper per day. It acted as an incentive to move relief inside the workhouse and ensured that unions remained within the central board's assessment of institutional accommodation. Between 1890 and 1895 the Fund provided 14.4% of the Whitechapel Union's income, bridging the gap between income and expenditure. Taking 1895 as a representative year, the Common Poor Fund partially supported the relief of indoor paupers (27.3%), salaries (25.1), the care of lunatics (20), and maintenance of pauper children at the district school (8.8). In effect it worked in a comparable way to the contributions from the LCC, but covered the services of the MAB and the Sick Asylums Districts. In this respect the Fund reduced expenditure on vaccination, paupers admitted to fever hospitals, and, after 1883, for the provision of ambulance services, though from the 1850s onwards the Whitechapel Union had its own service.<sup>50</sup> Mackay asserted that the Fund ensured that 'the candle of extravagant expense had been lighted at both ends', allowing expensive indoor institutions and freeing the poor rate for lavish outrelief.<sup>51</sup> The two were not often compatible, as a change in policy that allowed for institutional expansion was allied with a move towards

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<sup>48</sup> Whitechapel Archive, Correspondence, Wh/107/15.

<sup>49</sup> Whitechapel Archive, Guardians' Minutes, Wh/55.

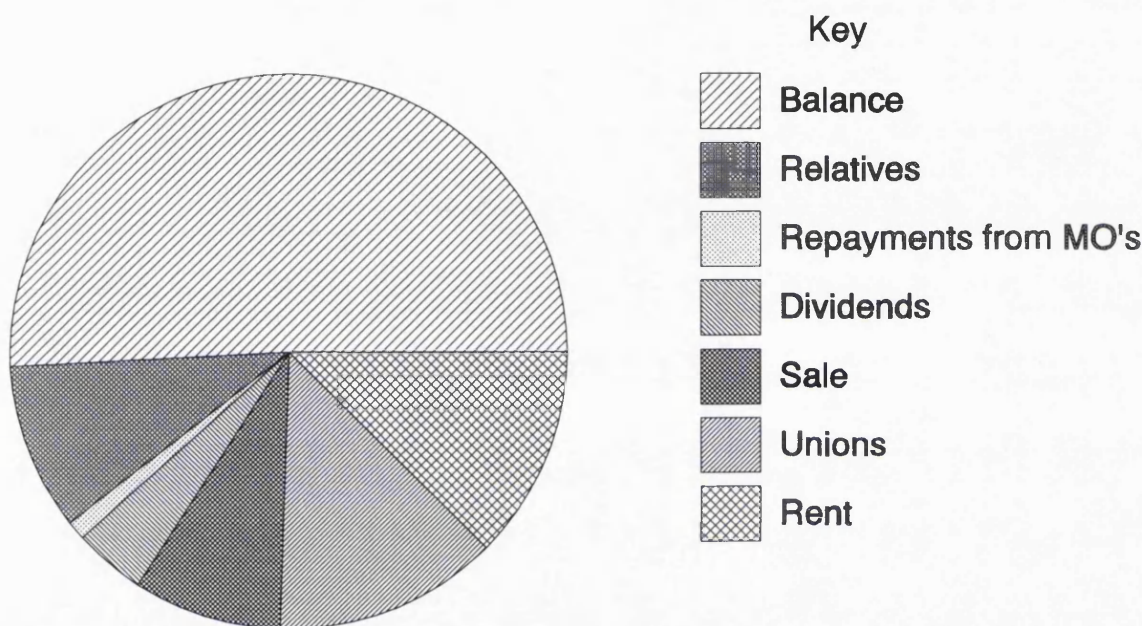
<sup>50</sup> Whitechapel Archive, Poor Fund Claims, Wh/144/3.

<sup>51</sup> T.Mackay, *History of the English Poor Law*, 3 (1899), 468.

limiting outdoor relief. Without the Metropolitan Common Poor Fund it is hard to imagine that many of the East End unions would have been able to afford the services of the MAB or the expenses it imposed through its encouragement of institutional growth.

Other sources of funding remained marginal, contributing 4.2% towards the Whitechapel Union's income:

Figure 7.3: Income (Other) 1890-95.



Source: Whitechapel Archive, Financial Statement, Wh/142/1.

Two factors are of particular interest. The heading 'Relatives' refers to the Union's policy of collecting money from an inmate's family for medical relief. From 1879, the remit of the New Poor Law, particularly in relation to the MAB, began to alter. Investigations had revealed that over 90% of those admitted under the MAB could be classified as non-pauper inmates, forcing a modification of the Poor Law. In response the 1879 Disqualification Act empowered guardians to recover 'the cost of maintenance' from those

who were deemed able to contribute. Initially only patients admitted to a fever hospital were covered, but under the 1885 Redistribution Act the principle was extended.<sup>52</sup> Given the contemporary concerns over pauperism, this was an attempt to solve the problem of treating non-pauper patients and recover the cost of their treatment.<sup>53</sup> The policy was not a complete departure from traditional practice. Under legislation in 1855, guardians could charge the East India Company for 'the relief of lascars and other natives of the territories' under their government.<sup>54</sup> However, with the Disqualification Act the policy was extended beyond those traditionally considered 'destitute', and directed at the individual who received treatment. Initially this was framed as a loan, but became a 'charge' payable over a twelve-month period. For example, in 1892 Morris V\_\_\_ was asked to pay £1 per month for the maintenance of Barnett R\_\_\_ in the infirmary, though Israel C\_\_\_ had to pay only 2s 6d per week for his wife in the same institution. A Maintenance Committee assessed and distributed charges, but there is no evidence to suggest that they were means tested or linked to treatment as the differing amounts appear to suggest.<sup>55</sup> Officials now expected relatives to support their kin, but as Hollen Lees notes, this regularly involved unions in law suits.<sup>56</sup> Vallance, clerk to the Whitechapel Union, expressed the belief that 'we get some of the money back, but not to any large extent. Where we do get it back it is rather through the persistence of the collector'.<sup>57</sup> Complications arouse because individuals felt they had a right to treatment under the Poor Law because it was administered by the state, a view hospital governors strongly

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<sup>52</sup> Guardians did not react favourably to the extension of categories of patients from whom they could recover costs. They admitted that patients with infectious diseases were a special case, but believed that expansion encouraged reliance on the Poor Law, reducing thrift. This attitude did not, however, hamper them in collecting maintenance when the Act was passed.

<sup>53</sup> *Lancet*, 1 (1879), 551.

<sup>54</sup> Whitechapel Archive, Correspondence, Wh/107/8.

<sup>55</sup> Whitechapel Archive, Guardians' Minutes, Wh/75.

<sup>56</sup> L.Hollen Lees, 'Survival of the Unfit: Welfare Policies and Family Maintenance in Nineteenth Century London' in P.Mandler (ed.), *The Use of Charity: The Poor on Relief in the Nineteenth Century Metropolis* (Philadelphia, 1990), 72.

<sup>57</sup> SC on Poor Relief, 513.

discouraged when it came to their own institution where treatment was projected as a privilege. Despite the difficulties of enforcement, the Local Government Board habitually reaffirmed its commitment to the principle of payment and the need for legal action if necessary and local unions did their best to comply.

‘Repayment from M.O’ was income derived in a comparable manner. The Union’s medical officers were entitled to use the Union’s facilities for their family, but had to pay for the privilege. As the stigma and electoral disqualification of infirmaries was gradually reduced, it is not surprising that medical officers treated their family within the confines of the Poor Law. It eliminated the problems of gaining entrance to a hospital and provided key medical services at a cost that was far below the market price.

Over time the New Poor Law’s finances had evolved to produce a structure of income that took account of changing policies and institutional expansion, rather than responded to shifts in public money. The result, as in the London hospitals, was financial diversification, a development that became a salient feature of the Whitechapel Union’s financial structure from the 1860s onwards.

## 2. EXPLAINING AWAY DIVERSIFICATION

The New Poor Law did not experience the same pressures faced by hospitals, but similarities exist between the two institutions. A change in the nature of income was broadly a consequence of expansion, the extension of provision and a resultant rise in expenditure. These experiences were shared by both institutions, making diversification a consequence of the institutional provision of healthcare in a changing environment rather than a phenomenon of a particular healthcare sector. At the same time as the London hospitals started to evolve more medical functions, a change occurred in the metropolitan Poor Law linked to an expansion of its services that had stark implications for union finance. From the 1880s onwards there was a tendency to ascribe development in the Poor Law to ‘the importunate demands of the working-class electorate - even though... many working class men were themselves ratepayers and showed little inclination to be

more extravagant than their middle-class counterparts'.<sup>58</sup> The impetus that had inspired the 1834 Poor Law had been modified by the 1890s in the face of a growing awareness of poverty and altered ideas as to its solution.<sup>59</sup> A more diverse financial structure and an increase in expenditure were the consequences. Wood recognised that 'by the late nineteenth century improvements in local finances had enabled Boards of Guardians, albeit reluctantly, to provide a range of services going beyond the relief of destitution'.<sup>60</sup> As the Local Government Board wrote,

since workhouses were established...the circumstances connected with the administration of relief, and the character of those for whom accommodation in workhouses has to be provided, have so materially changed.... It may be pointed out that whilst workhouses were in the first instance provided chiefly for the relief of the able bodied, and their administration was so intentionally deterrent, the sick, the aged and the infirm now greatly preponderate, and this has led to a change in the spirit of the administration.<sup>61</sup>

To care for the non-problematic categories of the aged, the sick and the young strained resources forcing provision to escalate beyond the simple relief of poverty.<sup>62</sup> The change was partly reflected in the union's administration. Like the hospitals' administration discussed in Chapter 5, new managerial functions were grafted onto the established administrative structure and new committees were established to manage additional services. In 1850 the Whitechapel Union had six subcommittees; eight were in operation by 1872; twelve by 1898.<sup>63</sup> These reflected the Poor Law's new purpose, as the Stone Yard Committee and the Medical Committee gave way to a Dispensary, Vaccination,

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<sup>58</sup> J.Harris, 'The Transition to High Politics in English Social Policy 1880-1914' in M.Bentley & J.Stevenson (eds.), *High and Low Politics in Modern Britain* (Oxford, 1983), 74-5.

<sup>59</sup> See E.P.Hennock, 'Poverty and Social Theory in England: The Experience of the Eighteen Eighties', *Social History*, 1 (1976).

<sup>60</sup> Wood, 'Finance and the Urban Poor Law', 46.

<sup>61</sup> Whitechapel Archive, Guardians' Minutes, Wh/107/43.

<sup>62</sup> Crowther, *Workhouse System*, 57.

<sup>63</sup> Whitechapel Archive, Guardians Minutes, Wh/13;Wh/54; Wh/80.

Infirmary, Boarding-out, and Children's committee. Expansion ensured that administration increasingly took more time than the sanctioning of relief.

Expansion is reflected in the increase in the number of cases relieved. Investigations of the Poor Law usually stress the avoidance of public relief by all classes of society, portraying the workhouse as a social nadir. Contemporaries and historians believed that 'the best of the working class will rather starve - and often do rather starve - than apply for [the workhouse]'.<sup>64</sup> Hollen Lees has, however, convincingly argued that the poor utilised the metropolitan Poor Law to solve temporary problems, negotiating relief on their own terms.

Table 7.2: Persons Given Poor Relief in the Metropolis on Sample Days in January (1850-1900)

Year	Indoor	Outdoor	Total
1850	9,806	44,330	54,136
1860	25,430	63,349	88,779
1870	36,868	98,711	135,579
1880	46,663	50,330	96,993
1890	61,533	41,500	103,033
1900	68,178	37,183	105,361

Source: Hollen Lees, 'The Survival of the Unfit', 73.

Workhouses were still feared and the prospect of a pauper funeral or the possibility of dissection inspired a sense of terror, but increasing numbers used the institutional services unions had to offer.<sup>65</sup> Given the incidence of small debt, especially in unstable labour markets like Whitechapel, resort to the Poor Law was often a necessity.<sup>66</sup> The poor saw

<sup>64</sup> Cited in D.Fraser (ed.), *The New Poor Law in the Nineteenth Century* (1976), 21.

<sup>65</sup> See R.Richardson, *Death, Dissection and the Destitute* (1988) for a highly detailed account of the 1832 Anatomy Act and the fears it generated.

<sup>66</sup> P.Johnson, 'Small Debts and Economic Distress in England and Wales 1857-1913', *Economic History Review*, 56 (1993), who links small debts (those under £20) to cyclical fluctuations in the labour market and falls in working-class income.

the workhouse as a ‘familiar and accepted donor of services’ and regularly asserted their right to relief.<sup>67</sup> Nowhere was this clearer than over maternity care and women frequently used the workhouse for their confinements.<sup>68</sup>

The shift towards the workhouse, reaching 59.7% of those relieved in 1890, marked a change in the nature of relief. The options had narrowed as the policies of 1834 were enforced with a new vigour. Inspiration came from Gladstone’s anxious attempts to cut public expenditure and minimise governmental activity, aided by the climate of ideas generated by the COS and the emphasis given to the full deterrent power of the workhouse in the Goschen Minute. The crisis of the 1860s and the fears aroused by urban pauperism did not result in a crude system of less-eligibility as the crisis of rural pauperism had in the 1830s, but a complex set of institutions to deal with the non-problematic poor and cooperation with scientific philanthropy to ensure that the right cases were assisted.<sup>69</sup> Relatively few in London could now obtain outdoor relief, and then only for short periods.

Table 7.3: Proportion of Adult Paupers Relieved Indoors (percent).

Category	1865	1875	1885	1895
Able-bodied males	31.25	53.33	65.71	76.59
Able-bodied females	17.67	24.80	34.28	45.50
Non-able bodied males	55.72	66.84	81.11	80.76
Non-able bodied females	35.76	35.49	50.58	47.70

Source: M.Mackinnon, ‘Poor Law Policy, Unemployment and Pauperism’, *Explorations in Economic History*, 23 (1986), 304.

Such restrictions inspired the growth of the workhouses’ ancillary services. Guardians were persuaded to accommodate applicants, forcing local unions to provide new

<sup>67</sup> Hollen Lees, ‘Survival of the Unfit’.

<sup>68</sup> L.Marks, ‘Medical Care for Pauper Mothers and their Infants: Poor Law Provision and Local Demand in East London 1870-1929’, *Economic History Review*, 46 (1993).

<sup>69</sup> See Rose, ‘Crisis of Poor Relief in England’.



institutions as expansion gave way to overcrowding. Simultaneously a growth in facilities allowed guardians to enforce the workhouse test as an alternative to outdoor relief. New wards, separate infirmaries, fever hospitals, asylums and district schools multiplied as a result. As Hollen Lees notes, 'by the late nineteenth century, metropolitan guardians of the poor dispensed aid largely through the medium of specialist asylums'.<sup>70</sup>

The high incidence of sickness in London, especially in the East End, meant that most of these new inhabitants were classified as sick. In 1870 sick paupers formed a third of those given relief in London. In the Whitechapel Union the proportion was higher with 88.5% of the workhouse's inmates sick or infirm.<sup>71</sup> MacKinnon ascribes the increase to 'improvements in hospital facilities' and the guardians' desire to use them.<sup>72</sup> Responsibility for vaccination and the separation of Poor law-infirmaries from the workhouse blurred the boundaries of welfare, reducing perceptions of pauperism and allowing the inclusion of greater numbers. The need for medical care, where the only proof was that the recipient could not afford a doctor, drove many to the state, partly because hospitals theoretically restricted the types of patient they treated. In response the state had to develop medical services, though medical officers were often overstretched and the sick were treated as a special case rather than with exceptional kindness. Of Whitechapel's own infirmary, Vallance reported that it was 'equal it may be said to a general hospital' and the level of medical care in the Whitechapel Union was better than many of the surviving images of the workhouse indicate.<sup>73</sup> The *Lancet*'s claim in 1865 acquired institutional justification as the New Poor Law gradually assumed a medical character.

The admissions to the Whitechapel Union's sick wards and later to the Baker's Row infirmary, expanding faster than the area's population, reflect this transformation:

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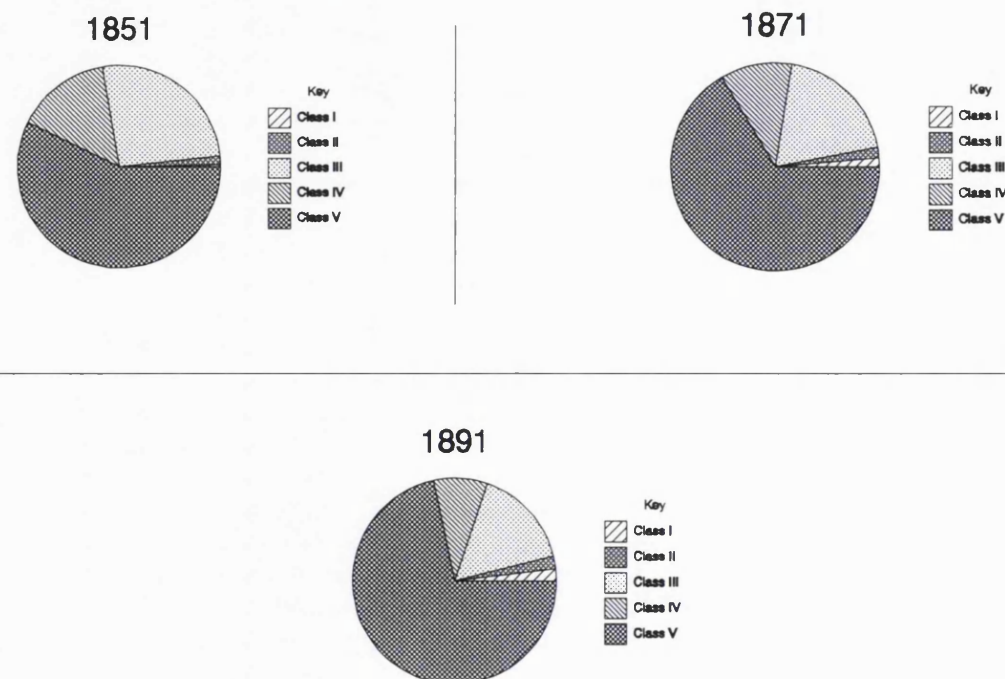
<sup>70</sup> Hollen Lees, 'Survival of the Unfit', 74.

<sup>71</sup> Whitechapel Archive, Guardians' Minutes, Wh/51.

<sup>72</sup> MacKinnon, 'Crusade Against Outrelief', 327.

<sup>73</sup> SC on Poor Law Relief, 492.

## Whitechapel Union: Patient Admissions.



Source: Whitechapel Archive, Patient Records, Wh/123/1, 10, 27 and 28.

The separation of the infirmary from the workhouse in 1876, physically isolating relief from treatment, the removal of the electoral disqualification for medical relief, and advances in medical science encouraged more to use the Union's medical facilities. As a result there was an improvement in conditions, for the more the workhouse was seen as an institution for the sick and infirm, the harder it was to justify a policy of deterrence. A positive virtue was made out of the infirmaries' superior conditions and the decisions of the relieving officers over who deserved relief were gradually replaced by those of the medical officers. 1878 marked a watershed in classification. Until then patients were admitted as 'destitute', but in 1879 this category was increasingly replaced by a medical label and whole families were now less likely to be admitted. The infirmary was evolving to become not just another outlet for relief, but an institution dedicated to the treatment of the sick poor. One anonymous Poor-law medical officer writing to the *Lancet* in 1877 could claim that 'there is little difference between the pauper who seeks the aid of a voluntary charitable institution and the pauper who is compelled through the exigencies of sickness and necessity to enter a poor-house infirmary'.<sup>74</sup> Using Banks's analysis of the census returns discussed in Chapter 5, a study of the Whitechapel Union shows that the occupational groups that had previously shunned the workhouse applied to the infirmary.<sup>75</sup> For the top two classes the percentage of cases admitted rose from 1.8% in 1851 to 3.9% in 1891.<sup>76</sup> This did not mean that the metropolitan Poor Law was now fully accepted as a viable source of non-pauperising medical care. Categories that could be considered above the working class and the traditional poor only represented a small proportion of those treated, rarely over 4%. The diversification in occupational make-up and the increase in admissions are important, but it was still the traditional occupational categories that made up the main body of the sick poor, suggesting a similar trend to the

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<sup>74</sup> *Lancet*, 2 (1877), 335.

<sup>75</sup> Women accounted for the major share of those on relief; children, apart from those born within the infirmary, were marginal. Women were included under the category of non-problematic poor as it was presumed that they would be dependent on their husband. However, women were economically and socially disadvantaged and suffered from a lower standard of health, making their entrance into the workhouse and more particularly into the infirmary a greater probability than their male counterparts: Thane, 'Women and the Poor Law', 33-36.

<sup>76</sup> Whitechapel Archive, Patient Records, Wh/123/1; Wh/123/28.

London hospitals' experiences. Even in 1895 labourers continued to make up 25.3% of admissions and the infirmary's inmates came from essentially poor and unhealthy residences in the Union:

Table 7.4: Residence of Whitechapel Infirmary Inmates (1894).

	Number	Percent
Own Residence	308	10.2
Shelters	431	14.3
Lodging Houses	980	32.4
Other Institutions & Homeless	370	8.9
Workhouse	971	32.0
Born in the Infirmary	66	2.2

Source: Whitechapel Archive, Governors' Minutes, Wh/67.

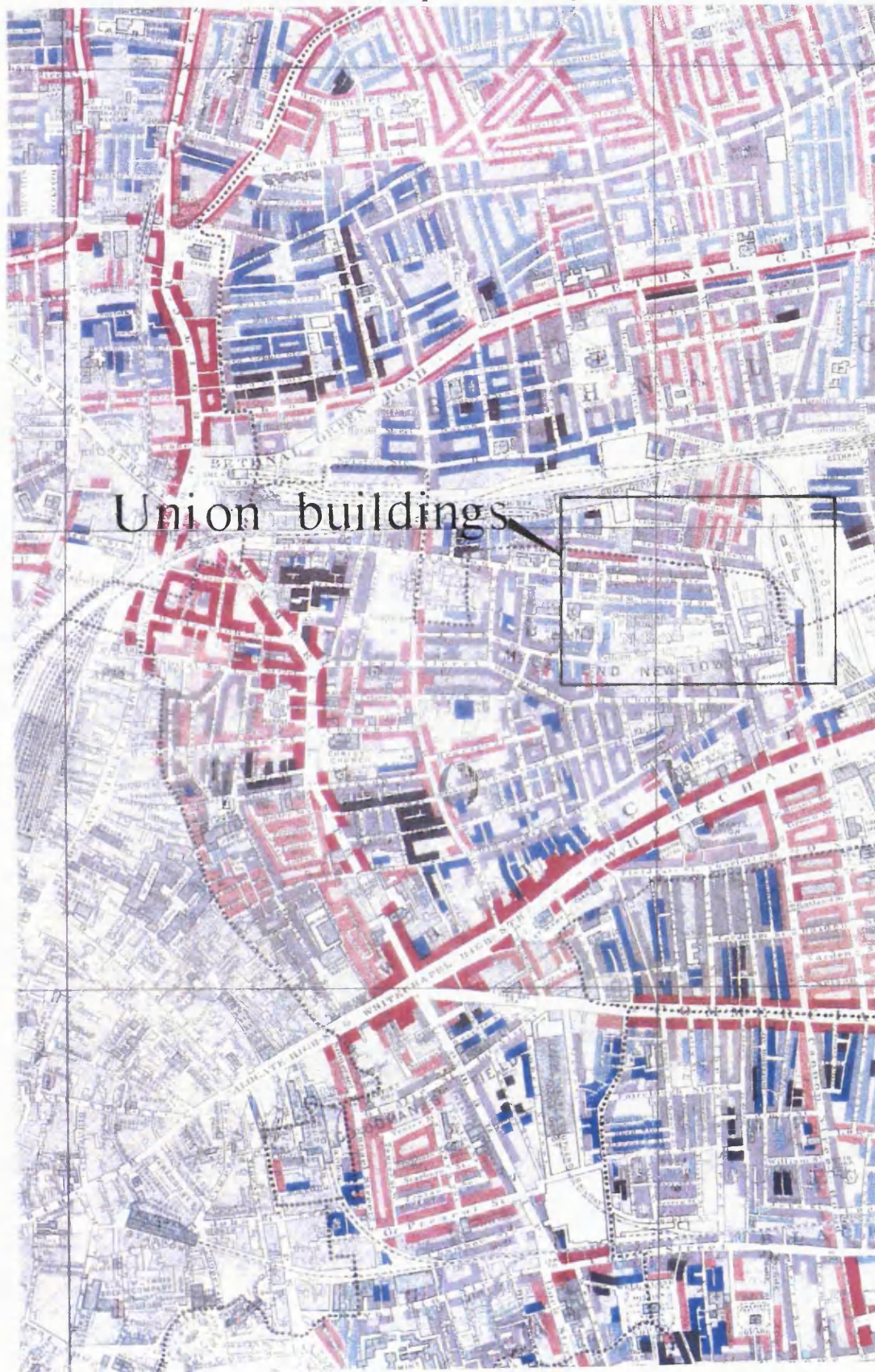
The categories that declined as a percentage (though increased numerically) were classes III and IV. A rise in income in these occupational groups allowed membership of a benefit society or permitted some access to private medical care, while increased perception of the value of hospital care encouraged more patients to seek relief there. The reasons for the predominance of class V can be found in the occupational structure and insanitary nature of the East End. A gradual change in the nature and image of Poor-law medical relief allowed a partial occupational transformation in admissions, rather than a complete reversal.

Under these circumstances expenditure could only spiral. A shift in the nature of the Poor Law to favour institutional relief realigned the balance of expenditure. The new emphasis on indoor relief and an expansion of medical care brought its own problems. Institutional medical care had an inherent trend towards increasing expenditure. By 1886 'with the single exception of Bethnal Green all large unions and parishes of the metropolis are now provided with infirmary accommodation...'.<sup>77</sup> Increasing expenditure was therefore built into the metropolitan Poor Law. Spending fluctuated annually following factors as diverse as the state of the economy and the severity of the weather,

<sup>77</sup> LGB, *15th Annual Report* (1885-86), 25.



## Charles Booth's Map of Poverty: Whitechapel Union



Source: C. Booth, *Life and Labour of the People of London* (1902), maps.

but given the scale of poverty in Whitechapel large-scale poor relief was inescapable. The East End was characterised as ‘a nursery of poverty and thriftless, demoralised pauperism’, ‘a community cast adrift from the salutary presence and leadership of men of wealth and property, and... a political threat to the riches and civilisation of London and the Empire’.<sup>78</sup> Henrietta Barnett described the area when she moved there with her husband Samuel Barnett in 1873: ‘the people were dirty and bedraggled, the children neglected, the streets littered and ill-kept, the beer shops full, the shops shut up’.<sup>79</sup> Sixteen years later, Booth’s survey revealed that 39.2% of the area’s inhabitants lived in poverty.<sup>80</sup> Poverty in Whitechapel was probably greater than Booth’s impressionistic survey revealed, but even according to his map the union’s main buildings were located close to the poorest areas (shown in black and dark blue on the map). Whitechapel was not the poorest area in London, but with only 5.4% of the residents considered ‘wealthy’ by Booth (shown in dark red), the majority had a precarious living among the maze of tenements and back street slums carved up by roads and railways. Dominated by the docks and small workshops, the main industries were based on sweated labour and furniture making, while other inhabitants survived as street pedlars or were casually employed as labourers. The district had a reputation for crime and viciousness, epitomised by the 1888 Whitechapel murders. It was within this neighbourhood that the Union provided its relief and it was its poverty that shaped expenditure.

The general national pattern favoured a dramatic increase in expenditure, mirrored in the scale of local government spending which quintupled between 1820 and 1880.<sup>81</sup> The 1860s saw a striking increase in national expenditure: from the quinquennium 1859-63 and 1869-73 spending rose by 3.5% per annum in England and Wales, for the following decade this had fallen to 0.3%.<sup>82</sup> By the 1870s capital expansion had slowed

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<sup>78</sup> N.Barnes, ‘The Doctors’ Hospital’ (Unpublished BSc. Dissertation, Wellcome Institute Library, 1993).

<sup>79</sup> H.Barnett, *Canon Barnett, His Life, Work, and Friends* (1918), 69.

<sup>80</sup> C.Booth, *Life and Labour of the People in London*, 2 (1902), 28.

<sup>81</sup> A.T.Peacock & J.Wiseman, *The Growth of Public Expenditure in the United Kingdom* (1961), 39.

<sup>82</sup> Wood, ‘Finance and the Urban Poor Law’, 22.

from the rapid transitional period of the late 1860s. Expenditure relating to the Whitechapel Union's new Baker's Row Infirmary alone rose from £15,483 in 1881 to £19,810 in 1892.<sup>83</sup> This was accompanied by an increase in the average cost per head rising from £26 1s 3d to £32 8s 3d. The Poor Law Board explained these developments in terms of the 'growing number of the more costly classes of pauper' and a 'higher standard of efficiency'.<sup>84</sup> The Local Government Board adopted and repeated this analysis, but included the expense of the MAB. Though Poor Law expenditure in England and Wales rose by 78.6% between 1873-4 and 1896-7, in London the equivalent rise was 90.3%.<sup>85</sup>

Table 7.5: Expenditure Increase in the Whitechapel Union.

Category:	Lady Day 1865	Lady Day 1895	Increase (%)
Outrelief	£2090 3s 11d	£100 18s 8d	-95.2
Lunatics	£1731 15s 5d	£3935 15s 8d	127.3
Registration Fees	£83 10s 6d	£160 5s	92.8
Vaccinations	£36 9s	£233 17s 4d	547.2

Source: Whitechapel Archive, General Ledger, Wh/145/2.

Indoor relief expanded at a greater rate than outdoor relief. Between 1871/2 and 1905/6 total indoor expenditure rose by 113%, though the number of indoor paupers increased by only 76%.<sup>86</sup> The Whitechapel Union shows this development on a local scale. The dramatic fall in outrelief, declining to £24 in 1898, was a reflection of Whitechapel's rigid enforcement of the workhouse test, though a further £54 4s 4d was awarded in outdoor medical relief.<sup>87</sup> Other items evolved with the metropolitan Poor Law. By 1895 the guardians paid £36 towards emigration, £3,124 towards the

<sup>83</sup> Whitechapel Archive, General Ledger, Wh/145/2.

<sup>84</sup> Poor Law Board, *22nd Annual Report* (1869-70), xii-xiv.

<sup>85</sup> Mackay, *History of the English Poor Law*, 469.

<sup>86</sup> M.E.Rose, *The Relief of Poverty* (1972), 41.

<sup>87</sup> Whitechapel Archive, General Ledger, Wh/145/2.

Metropolitan Sick Asylums District and £3,582 4s 8d to the MAB.<sup>88</sup> The relative weight of poor relief and medical relief within the metropolitan Poor Law had shifted, especially if the care of pauper lunatics is included. Increased numbers used the infirmary, and by 1900 it was medical care, both within the individual unions and in the wider context of the MAB, which had become the largest single item of expenditure, reflecting increased medical provision and the growth of specialist services.

No union could be entirely self-sufficient. Hospitals subscribed to other charitable institutions that provided specialist care and the Whitechapel Union equally had to maintain its paupers under other unions' care or pay for services it could not afford to provide itself. Though the Whitechapel Union had a district school until 1897, it lacked a separate asylum. Mostly pauper lunatics were sent to the Coley Hatch Asylum that charged 9s 7d per patient per week, but the guardians also had to pay for care in different unions and for patients it sent to the London hospitals.<sup>89</sup> In 1857 the London charged 1s 6d per day per pauper (a charge higher than paying patients were later expected to pay) and, given the London's structure of admissions that favoured accident and emergency cases, the Whitechapel Union signed a treatment agreement to ensure the admission of its paupers.<sup>90</sup> Specialist medical services were contracted out with the Union subscribing five guineas to the Royal Ophthalmic Hospital in 1865. This was necessary as the Industrial School was overrun with ophthalmia. By 1898 eleven separate charities were subscribed to, suggesting a comprehensive policy of cooperation between the union and local charity. Other contractual costs included the emptying of cesspools, internment fees at the City of London Cemetery, even the cost of barbers and advertisements for tenders and vacant positions.

Expansion alone was not the sole reason for rising expenditure, for pressure was also created by the local guardians' attitude to relief. In 1877 the *Lancet* commented that 'the system of the Poor-law administration has, in fact, resolved itself into an organisation for the discharge of a disagreeable duty with the least possible demand upon the

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<sup>88</sup> Whitechapel Archive, Financial Statement, Wh/142/1.

<sup>89</sup> Whitechapel Archive, Guardians' Minutes, Wh/54.

<sup>90</sup> Whitechapel Archive, Guardians' Minutes, Wh/21.



philanthropy of the ratepayer'.<sup>91</sup> The guardians of the Whitechapel Union did not fit this traditional model of parsimony. Despite Whitechapel being one of the four areas in London initially opposed to the New Poor Law, from 1850 the guardians were keen to expand provision, though poor conditions remained and efforts to remedy these were slower to emerge. If the history of workhouse medicine 'is really the story of attempts to raise the vast majority of establishments to the standard of a few', the Whitechapel Union could be considered better than many other unions in London.<sup>92</sup> The guardians operated a restrictive policy of outdoor relief, but had a more liberal attitude to the treatment of the non-problematic poor. In the 1860s the workhouse was rebuilt and a separate infirmary was added and regular improvements were made to both. Generally, increased expenditure involved small projects directed at improving conditions for the sick poor. To ease access to medical relief, the medical officer was instructed from 1859 to attend the relieving officer at the workhouse so that relief could be dispensed quickly and efficiently with minimum inconvenience.<sup>93</sup> New officers were provided as a result. A dispensary was included in the workhouse to achieve the same purpose. In their own words the guardians were 'ever willing to do all that can be done for the comfort of the poor under their care'.<sup>94</sup> To this end, they investigated the workhouse's management in 1861. On finding that medical relief was 'extremely unsatisfactory', they implemented a better system of classification and improved supervision.<sup>95</sup>

Part of the explanation for the Whitechapel Union's level of relief may lie in the attitude and character of its guardians. Lockwood, the Local Government Board inspector for London, believed that the alteration of the unions' electoral base in 1894 did not result in a sudden influx of working-class guardians, though the effect of men like Will Crooks and George Lansbury was significant.<sup>96</sup> The Progressive/Labour alliance characteristic of

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<sup>91</sup> *Lancet*, 1 (1877), 540.

<sup>92</sup> Longmate, *Workhouse*, 195.

<sup>93</sup> Whitechapel Archive, Guardians' Minutes, Wh/25.

<sup>94</sup> Whitechapel Archive, Guardians' Minutes, Wh/47.

<sup>95</sup> Whitechapel Archive, Guardians' Minutes, Wh/30.

<sup>96</sup> LGB, *23rd Annual Report* (1896-7), 76.

politics in the East End in the 1890s failed to disrupt the calm surface of policy in Whitechapel.<sup>97</sup> Political affiliations remained unclear and elections unobtrusive with only two or three contested wards.<sup>98</sup> The £40 electoral qualification ensured that the character of the Board remained higher than the poverty of the surrounding area. Yet most of the guardians were not Keith-Lucas's 'men of substance and property' and came from a lower social class than the active hospital governors identified in Chapter 5.<sup>99</sup>

Table 7.6: Occupational Background of Elected Guardians (1853-1873)

Category	1852	1863	1873
Gentlemen	2	4	4
Professional	2	1	1
Public Service	2	0	0
Teaching	0	0	1
Shop Keeper	7	7	6
Merchants	1	4	6
Manufacturing	5	7	2
Building Trade (small)	2	2	2
Printing	1	0	0
Clothing	2	1	2
Boot & Shoe	1	0	1
Transport	0	0	1
Wharfinger	2	0	1
TOTAL	27	26	26

Source: Whitechapel Archive, Guardians' Minutes, Wh/13, 33, 54.

Ratepayers were suspicious of all schemes that increased the burden on the rate and it is doubtful that the guardians of the Whitechapel Union thought differently.

<sup>97</sup> Ryan, 'Politics and Relief', 158.

<sup>98</sup> This was certainly not the experience in other unions. D.Fraser shows in 'Areas of Urban Politics' in H.J.Dyos & M.Wolff (eds.), *The Victorian City*, 2 (1973) that elections in Leeds became the settings for intense political battles, though board meetings generally remained apolitical.

<sup>99</sup> B.Keith-Lucas, *English Local Government in the Nineteenth and Twentieth Century* (1977), 13.

However, a personal knowledge of the conditions of the poor encouraged a sympathetic attitude to the non-problematic poor. The position of guardian itself could be precarious and though they came from the middling social groups in Whitechapel, they were not socially far from the classes they assisted. Thomas Lulham, for example, was removed from the Board in 1855 as he was no longer able to contribute to the poor rate.<sup>100</sup> As the same guardians were returned annually their attitudes provided institutional continuity. Given the unpopularity of the position and its time consuming nature, with meetings every week until 1876, this is not surprising.<sup>101</sup> Chadwick described these men as 'those whose attention and services are of little value', but it was these men who were responsible for the implementation of the Poor Law at a union level.<sup>102</sup>

Guardians had a natural inclination to serve on those committees that reflected their particular field of interest. For instance, in 1873 two builders were represented on the Building Committee; a druggist and a chemist on the Dispensary Committee.<sup>103</sup> Given the way contracts were awarded administrative involvement was often based on more than an interest in local government. Some guardians took a more active role. Vallance dedicated his life to the work of the Union and consequently much of the policy reflected his conceptions of relief. His influence was honoured in the renaming of Baker's Row as Vallance Road. In the 1860s Craven had a considerable leverage over policy, strongly influencing the establishment of a separate infirmary as a route to greater discipline among the able-bodied.<sup>104</sup> Thomas Brushfield dominated the Board as its chairman for much of the period. According to Henrietta Barnett he snapped out his orders, 'often before the applicant had stated his case, or the guardians had had any opportunity of giving their opinions'.<sup>105</sup> These men were determined to follow the Goschen Minute, elevating the importance of the workhouse.

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<sup>100</sup> Whitechapel Archive, Guardians' Minutes, Wh/17.

<sup>101</sup> Whitechapel Archive, Guardians' Minutes, Wh/58.

<sup>102</sup> Cited in Roebuck, *Urban Development*, 152.

<sup>103</sup> Whitechapel Archive, Guardians' Minutes, Wh/54.

<sup>104</sup> Whitechapel Archive, Guardians' Minutes, Wh/43.

<sup>105</sup> Barnett, *Canon Barnett*, 201.

Few of the guardians could match the influence of these three figures, though others gave their time in no less stinting a manner. John Authwaite (builder) sat on eight committees, Robert Gladding (bookseller) on six, as did Needman (gentleman); John Jacobs (builder) and Gould (chemist) were on five.<sup>106</sup> One of the more interesting figures is Canon Samuel Barnett, vicar of St.Jude's, who was nominated by the Local Government Board in 1873. It was Barnett, ably assisted by his wife Henrietta, who provided the founding impulse and much of the organisational enthusiasm for Toynbee Hall.<sup>107</sup> His ideas and habit of lumping applicants together in one mass found expression in the Union. As a confirmed advocate of self-help and 'educational' philanthropy his ideas initially coincided with those of the COS and he 'warmly supported the policy of abolishing out-relief'.<sup>108</sup> Regularly helping the Chairman in his decisions, he put questions to the relieving officers or advised applicants on what to do. In every instance he took down the names and addresses of the poor and visited them personally.<sup>109</sup> His ideas on education found expression in the discussions he initiated on agricultural settlements in 1888, resulting in a conference of London guardians and the Board's subscription to the Bird Tree Farm, Clavering, Essex.<sup>110</sup> Given the level of his activities outside the Union at St.Jude's and then Toynbee Hall, it is surprising that he found time to assist the guardians in their work or attend as regularly as he did.

Other concerns played a part in deciding policy that were not connected with occupational background, or the domineering ideas of the Board's leading members. Bad publicity when Hart investigated the workhouse in 1866 as a prelude to the 1867 Act caused a stir within the Union, as did many later reports hinting at inadequate provision, embarrassing the guardians into a flurry of activity.<sup>111</sup> Broader attitudes to the purpose

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<sup>106</sup> Whitechapel Archive, Guardians' Minutes, Wh/54.

<sup>107</sup> For Barnett's life see Barnett, *Canon Barnett*, and S.Meacham, *Toynbee Hall and Social Reform 1880-1914* (1987) for the work of Toynbee Hall.

<sup>108</sup> Barnett, *Canon Barnett*, 204-5

<sup>109</sup> Barnett, *Canon Barnett*, 205.

<sup>110</sup> Whitechapel Archive, Guardians' Minutes, Wh/70; Guardians' Minutes, Wh/75.

<sup>111</sup> Whitechapel Archive, Guardians' Minutes, Wh/40.

and method of relief helped rationalise and inform the Union's activities. The idea expressed by hospital philanthropists that medical care was an economy also found expression in the Poor Law. Thomas Dolan in his paper 'Poor Law Economics' believed, along with the leaders of the Poor Law Conference movement who occupied high-status positions, that it was an economy to provide an adequate system of medical relief as it was cheaper to treat well and quickly than to care for whole families because of sickness.<sup>112</sup> These views are best expressed by Rogers in his campaigns for improved medical care:

that a more liberal administration of poor relief meant true economy to the rate payers, because if they cut short sickness of the poor, and if they diminish the amount of deaths that took place amongst the breadwinners, they would, as the ultimate result, economise expenditure and out-relief.<sup>113</sup>

The Whitechapel Union was not immune from these ideas or concerns to lower the poor rate. For Vallance 'by admitting the man to the infirmary we take security for his early recovery, as well as for his early entrance into the labour market again'.<sup>114</sup> To this concern they added the condition that the recipient of medical relief had to participate in a provident scheme after treatment. The guardians were adopting a vocabulary of relief that reflected the COS's rhetoric, but at the same time this linked effective medical relief to a reduction of the poor rate, producing an incentive to provide improved standards of care. The development of the Poor Law services encouraged the guardians' own apparent inclinations.

The other side of expenditure was less progressive, but no less practical. For a short period in 1868 an assistant to the relieving officer was appointed to check the background of those receiving medical relief in an effort to prevent imposture.<sup>115</sup> The aim was to remove needless burdens on the rates, invoking images of the COS's activities. More frequently, rewards were used to find abandoned children's parents or the relatives

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<sup>112</sup> *Lancet*, 2 (1897), 1306-8.

<sup>113</sup> J. Rogers, *Reminiscences of a Workhouse Medical Officer* (1889), 239.

<sup>114</sup> SC on Poor Law Relief, 492.

<sup>115</sup> Whitechapel Archive, Guardians' Minutes, Wh/67.

of inmates. For instance, in 1884 James M\_\_\_\_ was given £1 1s for the apprehension of Charles C\_\_\_\_ who had 'deserted his three children leaving them chargeable to this Union'.<sup>116</sup> It became a common solution to the problem of rising expenditure and an attempt to enforce kinship obligations. Even emigration was considered as 'a means of dealing in a hopeful and effectual way with much of the poverty in this country arising from want of employment', an idea that joined with notions of self-help.<sup>117</sup> For many it was the only way out of the East End, though the Whitechapel guardians did not go out of their way to help those considering emigration. In 1875 only one case was supported and nationally in 1890 only 471 cases at a cost of £4,462 6s.<sup>118</sup> Against this the guardians did attempt to restrict expenditure, although the desire for economy often restricted relief. For example, in 1861 Richardson, the workhouse medical officer, was 'requested' to review his use of improved diets as medical extras to the old and infirm. The aim was to restrict extra food to the 'medically necessary'.<sup>119</sup> All contracts were advertised and the lowest tenders were adopted. The allocation of a task of work provided a free work force that could be directed to useful improvements around the Union, though the guardians disliked the scheme of public works. Operating behind an educational role to encourage the traditions of labour, it served to combine theory with practical benefits.

New sources of income had to be created as a consequence of expansion and the associated escalation of expenditure. Sydney Waterlow, addressing the Select Committee on Metropolitan Government in 1867, believed that if local taxation was increased 'many of those who are now taxpayers will become receivers of rates; for it would necessitate the raising of rents to the extent... of the increase of local taxes, because what the landlord pays in rates the tenant must pay in rent'.<sup>120</sup> Without fiscal diversification the same degree of expansion would not have been possible and would have strained the rates,

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<sup>116</sup> Whitechapel Archive, Guardians' Minutes, Wh/47.

<sup>117</sup> Whitechapel Archive, Guardians' Minutes, Wh/66.

<sup>118</sup> Whitechapel Archive, Correspondence, Wh/107/23; LGB, *20th Annual Report* (1890-1), xciii.

<sup>119</sup> Whitechapel Archive, Guardians' Minutes, Wh/30.

<sup>120</sup> SC on Metropolitan Local Government, *PP* 1867 XII, 104.

outcomes the government wanted to avoid. The financial structure of the Whitechapel Union presents parallels with the hospitals' structure of income. Neither the metropolitan Poor Law or the London hospitals drew on the same type of resources, and even used loans in a different manner, but as providers of institutional healthcare they experienced similar pressures on their income that made diversification a consequence of expenditure and growth. In the Poor Law, resources were tailored to institutional expansion: by 1890-5 30% of the income came from outside the Union's poor rate. An inhibiting financial framework based on the rates, on which the acceptable limits of expenditure were set, was replaced by one tailored to growth. The Metropolitan Common Poor Fund and contributions from the LCC were added to the old staples of loans, sales, and grants. These complicated the fiscal policies of the metropolitan Poor Law and created a system where the 'charge' was continuously redistributed within London between local and central government. This is not to say that economic expansion and an associated rise in the standard of living did not have an effect. Whitechapel's rateable value rose by 17.6% between 1871 and 1881, enlarging the Union's income.<sup>121</sup> However, without new sources of funding an already overburdened rate would have failed to keep pace. They met the expenditure for which the loans and changing trends in relief allowed the facilities. As in the London hospitals, there was not so much a strategy of finance, more an *ad hoc* expansion of central services to meet increased demands and provision.

### 3. LOCAL AND NATIONAL AUTHORITY

A change in the level of charitable contributions in the London hospitals did not modify the governors' authority as the institution remained governed by voluntary principles. However, the modification of the metropolitan Poor Law's financial base did partially encourage a modification of the guardians' authority. The same forces remained, but their ability to control the decision process was modified as elements within the Poor Law were now capable of asserting their influence to a higher degree than previously.

Patterns of authority within the metropolitan Poor Law remained blurred and indirect, though ultimately government and parliament were the arbitrators of action.

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<sup>121</sup> LGB, *10th Annual Report* (1880-1), 463.

After 1847 the central board was given a direct representative in the House of Commons, allowing the issues and problems surrounding the Poor Law to be discussed freely and at the same time making sure that policy and action were defended, or at least explained. Local guardians were at the heart of a conflicting network of influences. They distributed authority within the union, but were themselves constrained by their financial base and by the wishes of the ratepayers, vestries, central board and government. As income was diversified, the guardians became less reliant on the poor rate for expansion, and as a result they could pursue their policies with greater freedom.

Within this matrix the Poor-law medical officers, unlike their counterparts in the London hospitals, experienced a slower path to professional control.<sup>122</sup> Under the New Poor Law medical officers were reduced to the status of employees and lost much of the influence they had enjoyed under the old system. Conflict, however, was still apparent. Hodgkinson portrays the Poor-law medical officers as a group regularly in conflict with the guardians as they attempted to implement more enlightened practices at a local level, while struggling for influence nationally.<sup>123</sup> Rogers gives a vivid account of these conflicts in his *Reminiscences of a Workhouse Medical Officer*, outlining the medical officers' extensive duties, their low salaries, and the problems they encountered.<sup>124</sup>

Under the 1858 Medical Qualifications Act all medical officers had to hold a legally recognised qualification, often in both surgery and medicine. Unlike the General Medical Council the central board and Poor Law Medical Officers Association worked energetically to remove the unqualified, making Poor-law doctors better qualified than many in private practice. However, competition in the wider medical market joined with local parsimony to ensure that salaries remained low: for the *Lancet* salaries were 'a sum of money... which alone can, except for his [the medical officer's] feelings, secure the worst attendance from him'.<sup>125</sup> Positions were at least permanent from 1855 and gave a 'publicly guaranteed introduction to the neighbourhood', a factor Digby highlights in her

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<sup>122</sup> See Chapter 6.

<sup>123</sup> Hodgkinson, *Origins of the National Health Service*; R.G.Hodgkinson, 'Poor Law Medical Officers of England', *Journal of the History of Medicine*, (1956).

<sup>124</sup> Rogers, *Reminiscences*.

<sup>125</sup> *Lancet*, 1 (1856), 326.



study of the economic dimensions of medical practice.<sup>126</sup> Given the employment prospects for newly qualified doctors in London's uncertain medical market posts were eagerly competed for, strengthening the local unions' position and doing nothing for the status of Poor-law medical appointments.<sup>127</sup> Sir James Paget, in his evidence to the Royal Commission on the Medical Acts in 1882, explained that 'a man with a title, and eligible to high office in hospitals would be deemed a man of higher rank than one eligible only to an office under the Poor Law...'.<sup>128</sup> Improvements were unable to dislodge the second-class reputation of Poor-law medical practice, and it was generally viewed as 'little better than the rubbish heaps of practice'.<sup>129</sup>

Control over the medical officers was exercised through central directives. Duties did not substantially change throughout the period, but were modified to take account of institutional expansion. There was, however, no guarantee that the guardians would adopt the central directives. It was not until 1896 that the medical officers' duties were clearly stated, with a stress on personal attendance, regular reports and records, examination of applicants, combined with directions for classification and treatment.<sup>130</sup> The absence of regular inspections prevented the directives from being enforced, though in the Whitechapel Union the guardians regularly requested the medical officers to account for their poor record keeping and neglect.

Medical officers were not passive in the transformation of the Poor Law. In 1871 the reconstituted Poor Law Medical Officers Association presented a nine point programme for improvement. The programme called for a general reform in medical care: more dispensaries and consultancies, and midwifery cases to be placed under their control.<sup>131</sup> More disinterested demands were voiced in 1874 but overall the response was

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<sup>126</sup> A.Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine 1720-1911* (Cambridge, 1994), 244-9.

<sup>127</sup> S.S.Sprigge, *Medicine and the Public* (1905), 146.

<sup>128</sup> RC on the Medical Act, *PP* 1882 XXIX, 28.

<sup>129</sup> Crowther, *Workhouse System*, 156.

<sup>130</sup> J.Brand, 'The Parish Doctor: England's Poor Law Medical Officers and Medical Reform 1870-1890', *Bulletin of the History of Medicine*, 35 (1961), 104.

<sup>131</sup> Brand, 'Parish Doctor', 114-7.

languid. The Local Government Board took a leisurely approach, concluding in 1878 'that there were no sufficient grounds for materially interfering'.<sup>132</sup> The Association shifted to defending individual officers, but continued to debate the now familiar grievances without the reforming spirit of the 1850s and 1860s.<sup>133</sup> It was hampered by its part-time nature and an equivocal attitude to the state. The Association complained of apathy while the medical officers were naturally ambivalent to the system as duty and self-interest conflicted.<sup>134</sup> Demands were limited to the tangible matters of remuneration, improvement of infirmary construction and working conditions. Even with the support of the BMA, the medical officers' professional position was only gradually advanced. The central board remained deaf to many of their calls for reform and only adopted superannuation, the main demand, in 1895 once the Local Government Board had come under the control of the more sympathetic Walter Frost. It was a limited success rather than a major victory and although the Local Government Board had an interest in improving infirmaries, it was not necessarily extended to the position of their staff.

Not only were abuses ignored at a national level, in terms of local administration the medical officers were in a subordinate position, dependent on the individual Boards of Guardians' attitudes to medical relief. Appearing infrequently in the minutes and rarely being consulted in decisions, the medical officers failed to achieve an influential position even at an informal level. Low salaries and competition meant that medical officers could be easily victimised. Standard wage levels were set by the central board and guardians were expected to ensure that a certain uniformity existed. It is indicative that while Richardson was paid £110 in 1870, the chief relieving officer received £130, while some full-time Medical Officers of Health were paid as much as £500 per annum.<sup>135</sup> Infirmary salaries represented £1,100 14s 2d from a total of £3,826 11s 6d spent on salaries in 1895, but this figure included the salaries of the nursing staff, imbecile attendants and domestic

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<sup>132</sup> LGB, *8th Annual Report* (1878-9), xlv.

<sup>133</sup> M.A.Crowther, 'Paupers or Patients?', *Journal of the History of Medicine*, 39 (1984), 34.

<sup>134</sup> Crowther, *Workhouse System*, 41-3.

<sup>135</sup> Whitechapel Archive, General Ledger, Wh/145/2; Staff Ledger, Wh/147/1; M.J.Peterson, *The Medical Profession in Mid-Victorian London* (Berkeley, 1978), 111.

staff. The general officers were paid £1,023 17s 6d, stewards £1,058 13s 8d, and the workhouse staff £643 6s 2d.<sup>136</sup> The disparity remained in 1895, though the Whitechapel Union compared favourably with other unions. In the 1850s medical salaries in the north were approximately £50 per annum and frequently medicine had to be provided out of this.<sup>137</sup> The medical officers did have one advantage: they could charge for additional services in the form of special fees, and they made strenuous efforts to secure vaccination posts to increase their salary. There was, however, no guarantee that the guardians would acknowledge these extra fees, retreating behind contract agreements and medical officers often had to carry out lengthy negotiations. Lunacy fees, according to Rogers, were particularly difficult to recover, negating the medical officers' decisions.<sup>138</sup> A salaried position, made more important as private practice was marginalised by the time demanded by Poor Law commitments, meant that they were employed by the guardians and so essentially at their mercy; a strident policy might alienate the guardians and immediately remove potential private patients. Inferiority was reinforced by 'subjective' pension arrangements that persisted until 1895. It was the guardians who decided the extent of superannuation and, if Hannah's argument is followed, this was used to impose an element of control, ensuring a non-confrontational policy in a sector of the medical profession that was ill-equipped to provide for retirement.<sup>139</sup> The whole ethic of the Poor Law, which reinforced the medical officer's prejudices, added to these problems, breaking 'the spirit of a man who cares anything about his professional work to have to go year after year pretending to deal with cases, which have come to him only when destitution has set in and therefore usually too late for any permanent remedial treatment'.<sup>140</sup> An impotency over the wider social problems which the medical officers' continually faced consequently

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<sup>136</sup> Whitechapel Archive, General Ledger, Wh/145/2.

<sup>137</sup> J.V.Pickstone, *Medicine and Industrial Society* (Manchester, 1985), 88-9.

<sup>138</sup> Rogers, *Reminiscences*, 69.

<sup>139</sup> L.Hannah, *Inventing Retirement: The Development of Occupational Pensions in Britain* (Cambridge, 1986).

<sup>140</sup> Cited in Hodgkinson, *Origins of the National Health Service*, 427.

sapped much of their strength and enthusiasm, greatly affecting the power they were capable of asserting.

Within the Whitechapel Union the medical staff were bypassed and given no formal capacity. The Medical, and later the Infirmary Committee, consisted of builders, gentlemen and shopkeepers, but no doctors. The situation was the same in many other unions, and whereas most London hospitals had an element of medical representation, the *Lancet* in the 1890s was still struggling to introduce the basic principle into the Poor Law. In the Whitechapel Union, Dr Nash's suggestions for improvements in 1851 resulted in a special committee but neither he or any of the medical staff were included in the resultant discussions.<sup>141</sup> Medical officers were not consulted over appointments; responsibility was left to the guardians who used their own notions of qualification to guide them. Because of this it is difficult to determine how much informal power the doctors wielded. The medical staff at the Whitechapel Union were probably in a more favourable position than many of their contemporaries given the guardians' receptive attitude to medical relief. This did not prevent the guardians from remaining within the conventional standards of low salaries, resistance to approve fees, overwork in large districts and intervention in treatment. One guardian even supplied medicine in 1859 without consulting the staff.<sup>142</sup> The guardians deferred to the medical officers' opinions when it suited them, especially over outbreaks of infectious diseases and the medical staff were called to report to the Board when their professional knowledge was needed to assert the guardians' decisions in the face of the central authority's questioning. A nominal control of the infirmary and admissions was tempered by the function of the relieving officers who had to sanction all cases of relief, even those admitted as emergency cases. This reached such proportions in 1868 that Richardson was ordered to allow the relieving officer to vet all his cases, marking the high point in the relieving officers' power.<sup>143</sup> After this, more informal cooperation developed between the two groups and infirmary admissions were placed on a stronger medical footing. Officers constantly had to refer to the workhouse master, denying the doctor power in areas where his professional skill

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<sup>141</sup> Whitechapel Archive, Guardians' Minutes, Wh/13.

<sup>142</sup> Whitechapel Archive, Guardians' Minutes, Wh/26.

<sup>143</sup> Whitechapel Archive, Guardians' Minutes, Wh/45.

could have been most beneficial.<sup>144</sup> Poor-law medical officers therefore worked in a more restricted and precarious environment than doctors in even the most conservative hospitals. Conflict periodically resulted in the threat of dismissal. The master of the industrial school in 1861 complained that Dr Banks did not 'promote that harmony in its management which is so essential to the interests of the establishment'. He was saved by the disunity of the guardians, but eventually resigned after further protests and the threat of an inquiry.<sup>145</sup> The fall in the number of dismissals did not mean that abuses occurred less frequently. Certainly, the rising status of the medical profession in general and the growth of scientific medicine noted in Chapter 6, had some effect in increasing the medical officers' status and influence; however, it was never given institutional form. Medical officers remained hampered by their low status and salaried position and only in 1913 did they achieve control over their own workplace. Gradually, even the medical officers' suggestions in the Whitechapel Union began to become less frequent, virtually vanishing by the 1880s, though even after the 1870s the medical officers' presence at the Board's meetings was rarely requested.

It was between the Poor Law guardians and the central board that the nature and measure of authority was decided in a permanent struggle for influence. No comparison existed within the voluntary sector, as hospitals remained independent, effectively ignoring outside pressure unless income was at stake. Much of the discussion within the Poor Law was over finance, and it was finance that increased the central board's impact on local policy. The central authority was hampered by the faith placed in the idea of a minimal state noted in Chapter 2, and the controversy surrounding state intervention. The central board's responsibilities and power were shaped by notions of local autonomy and the leading, but not absolute dogmas of *laissez faire* and voluntarism. As J.S.Mill wrote, 'centralisation was, and is, the subject not only of rational disapprobation, but unreasoning prejudice'.<sup>146</sup> Attitudes to governmental growth were inconsistent and often contradictory, but certain currents favoured local government. The work of Smith, Ricardo and Senior

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<sup>144</sup> Crowther, *Workhouse System*, 160.

<sup>145</sup> Whitechapel Archive, Guardians' Minutes, Wh/31; Guardians' Minutes, Wh/33.

<sup>146</sup> J.S.Mill, *Autobiography* (New York, nd), 146.

provided a justification for the autonomists, building on the individualist ethos.<sup>147</sup> A mass of historical writing, including the work of Sharon Turner and Thomas Macaulay, attempted to recover and preserve documents of the English past, and a major revival in Anglo-Saxon studies around John Mitchell Kemble and Sir Francis Palgrave, reintroduced a deference to a heroic English past, a reverence for Anglo-Saxon law, the certainty of progressive improvement, and an insistence upon the traditions of limited government.<sup>137</sup> The *Edinburgh* and *Westminster Review*'s ardently propagated these views, teaching men to be trustful of economic laws and suspicious of government intervention. Tolmin Smith championed the conviction that the parish was the true centre of government.<sup>138</sup> Even the Benthamites did not seek more government, only better government, and the arch centraliser, Chadwick, saw the role of central government as aiding local initiative through advice and investigation. These ideas helped shape legislation, at least until the 1880s. Government sought to persuade rather than coerce, and there was a reluctance to impose measures without local consent.<sup>139</sup> Administrative control worked within the environment of local autonomy.

Arguments over the necessity and extent of state intervention prejudiced the character of the New Poor Law and established a bias that was never entirely removed.<sup>140</sup> The Poor Law had a double character, following Mill's assertion that 'the principal business of the central authority should be to give instruction, of the local authority to apply it. Power may be localised, but knowledge, to be most useful, must be centralised'.<sup>141</sup> The central board adopted a supervisory role providing information, offering advice and establishing guiding principles; local administration had the

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<sup>147</sup> O.MacDonagh, *Early Victorian Government 1830-1870* (1977), 9.

<sup>137</sup> W.C.Lubenow, *The Politics of Government Growth: Early Victorian Attitudes Towards State Intervention 1833-48* (Newton Abbot, 1971), 25-7.

<sup>138</sup> J.Redlich & F.W.Hirst, *The History of Local Government in England* (1958), 150-1.

<sup>139</sup> W.Thornhill, *Central Government and Local Authorities* (Sheffield, 1954), 16.

<sup>140</sup> See Lubenow, *Politics of Government Growth*, 30-69, for the early influences of the state intervention debate within the Poor Law.

<sup>141</sup> Cited in R.Gutchen, 'Local Improvements and Centralisation in Nineteenth Century England', *Historical Journal*, 14 (1961), 85.

responsibility for implementation. In 1866 the *Lancet* gave a dismal verdict: 'the worship of local self-government has been a sort of fetishism, and we have consented to accept as tyrants local boards without a shadow of administrative knowledge or executive capacity'.<sup>142</sup> The central board could not act without the approval of the local guardians' and ultimately of the ratepayers whom they represented. Initially even such limited central authority was seen as too much. *The Times* compared the Poor Law Commission to the Court of the Star Chamber and jubilantly greeted its abolition in 1854. Critics associated all the problems in the social and political order to its existence and the Commission was labelled as a despotic and unconstitutional agency, 'pumped up to create patronage, and to satisfy the longing expectancy' of the friends of the liberal government.<sup>143</sup> This initial unpopularity coloured local authorities' conceptions of the central board, encouraging them to be distrustful and cautious.

Changes within the Poor Law altered the name and nature of central board. After the abolition of the Poor Law Commission in 1854, duties were passed to the Poor Law Board which itself was incorporated into the Local Government Board in 1871. The Local Government Board ran counter to Gladstone's faith in local self-responsibility and was created to impose greater uniformity on the practice of local government. Responsibility over the Poor Law was merged with its public health duties and miscellaneous other local activities.<sup>144</sup> However, even under the Local Government Board, the central board lacked a guiding hand. Presidents came and went quickly with the post having a low appeal and at best being considered a stepping stone to higher office. As Macleod notes it suffered from the consequences of Gladstonian financial methods, in which all expenditure was resisted, and the number of inspectors remained impractically low.<sup>145</sup> The consequence was that the central authority was rarely a dynamic force for change, with a fitful, conservative approach to problems. Action and policy were through

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<sup>142</sup> *Lancet*, 1 (1866), 392.

<sup>143</sup> Lubenow, *Politics of Government Growth*, 48.

<sup>144</sup> P.Thane, 'Government and Society in England and Wales 1750-1914' in F.M.L.Thompson (ed.), *Cambridge Social History of Britain 1750-1950*, 3 (1990), 37

<sup>145</sup> R.Macleod, 'The Frustration of State Medicine 1880-1899', *Medical History*, 11 (1967).

case work generated by the exercise of its statutory duties, and consequently most of the board's work was reactive rather than proactive. Given the weight of business and the emphasis on the disposal of statutory duties, this is not surprising. The only long-term policy was the encouragement of indoor relief and from this many of the developments within the metropolitan Poor Law emerged. However, the central board did its best to enforce state policy and the ethic of 1834. The effect was a ritual dance of power, mainly favouring the local administration.

The central authority had a particular interest in controlling expenditure. It is perhaps here that the board had its greatest success, remaining the ultimate arbitrator on spending despite Treasury opposition to the detailed monitoring of local government by any central department. The other aspects of fiscal policy were only dealt with in response to legislation or when the issue was raised by ratepayers or by the union's constituent parts. The central board indirectly sought to defend the ratepayers' interests and adopted a cautious and moderate policy. Even during the severe winter of 1871 the board stressed 'the importance of granting relief for the shortest possible periods'.<sup>146</sup> For many items the central board retained the final sanction on spending. In 1884 the Local Government Board approved new nurses' accommodation for the Whitechapel Union's infirmary, but controlled provision by setting the maximum expenditure at £1,200, though allowing £1,100 of this to be borrowed.<sup>147</sup> Both the Poor Law Board and the Local Government Board controlled expansion and to some extent provision, by retaining a check on local union expenditure.

The central board was not completely obstructionist when it dealt with finance. Despite Bellamy's claims that the Local Government Board failed to use grants positively to promote national policy and had few financial inducements to offer, economic incentives were regularly invoked to manoeuvre local boards into following its policy.<sup>148</sup> As the system of grants-in-aid had not been completely effective the policy was updated with the Metropolitan Common Poor Fund and the LCC's contributions. Here the central board could use financial incentives as an instrument of policy. A change in direction

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<sup>146</sup> Whitechapel Archive, Guardians' Minutes, Wh/52.

<sup>147</sup> Whitechapel Archive, Guardians' Minutes, Wh/67.

<sup>148</sup> Bellamy, *Administering Central-Local Government Relations*, 67.



towards an overt encouragement of the workhouse was reflected in contributions (see figure 7.1), which rapidly expanded on a national scale after 1874. If the board had not provided new sources of funding it is doubtful how much the metropolitan Poor Law at a local level would have been able to develop.

The case of outdoor relief clearly illustrates this point. Administration, in the Webbs' words, 'tightened up' to return to the principles of 1834. In 1870 indoor paupers were included in the grants awarded by the MAB and were a component in the LCC's contributions. This reinforced the Local Government Board's attempts to restrict outrelief and manipulated the ratepayers' natural inclination towards parsimony. More were now relieved within the workhouse, but Vallance, while admitting that this assisted the 'diminution of out-door relief' also stated that 'at the same time I am not disposed to attach so much weight to it as is generally done'.<sup>149</sup> The coincidence, as the 1888 Select Committee on Poor Relief found, was too hard to ignore. Mackay echoes the Select Committee's view, claiming:

the general effect of these financial arrangements might have been expected to be that Guardians would incline towards institutional methods of relief, of which practically the whole charge was taken off the local rate. The spending part of the policy thus recommended was easily learnt. A great impetus was given to increasing the costliness of the indoor establishments.<sup>150</sup>

The Whitechapel Union had introduced its restrictive policy in response to the rise in expenditure during the harsh winter of 1869/70 and the Local Government Board's suggestions. The transformation was gradual. It was one area of policy where complete agreement could be reached. Zealots within the Board, chiefly Vallance, wholeheartedly adopted the policy and made Whitechapel a model administration. From a union without a systematic policy, granting doles of outrelief and using the stoneyard for the unemployed, the Whitechapel guardians closed the stoneyard in 1870, sent the able-bodied to the workhouse, built an infirmary, and dealt with the old, widows and children as best

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<sup>149</sup> SC on Poor Law Relief, *PP* 1888 XV, 515.

<sup>150</sup> Mackay, *State and Charity*, 466.

they could, assisted by charity.<sup>151</sup> Statistically the results were spectacular with only one in ten offered relief willing to enter the workhouse. Other unions in the East End, particularly St. George's-in-the-East and Stepney, followed. MacKinnon believes that the 'Crusade against Outrelief' was motivated by mainly economic concerns.<sup>152</sup> However, this interpretation ignores the moral and theoretical dimensions of state assistance and the guardians' active cooperation with the COS. Outdoor relief in the Whitechapel Union persisted, but only for exceptional cases. As Vallance explains, 'it is rather hereditary pauperism and the permanent form of relief that we have set our forces against'; no mention was made of expenditure or economic incentives.<sup>153</sup> Even those promoting the policy at the Local Government Board had strong ideological reasons for adopting it: the permanent secretaries between 1871 and 1919 and the inspectorate led by Davy was steeped in Chadwickian and COS ideology.<sup>154</sup> It is doubtful how many ratepayers knew anything about the different incidence of the cost of indoor against outdoor relief; what was more important were conceptions of pauperism and the wealth of literature and debate on the subject.

Central control was customarily not as defined or as blatant as this. As an essentially authorising body the central board possessed the capacity to modify the guardians' requests. For a matter to be implemented it had to have the board's approval. All details were covered from new buildings to the burial of paupers. The ability to nominate guardians, mainly drawn from the clergy, gave the central board a further indirect influence. It was hoped that 'persons of better education and position than the small-tradesman class which principally served the office' would be introduced.<sup>155</sup> In the Whitechapel Union the Local Government Board's nominees were particularly active, and Samuel Barnett, as noted, proved a conscientious member. Reports from Poor Law inspectors generally had a more direct impact, encouraging guardians to improve facilities

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<sup>151</sup> Whitechapel Archive, Guardians' Minutes, Wh/80.

<sup>152</sup> MacKinnon, 'Crusade Against Outrelief'.

<sup>153</sup> SC on Poor Law Relief, 407.

<sup>154</sup> P. Waller, *Town, City and Nation: England 1850-1914* (1991), 277.

<sup>155</sup> Cited in Ryan, 'Politics and Relief', 141.

or make alterations. Essentially unqualified and limited in number, it was these inspectors who interpreted the Local Government Board's policy to the guardians.<sup>156</sup> They relied on the authority of their position, social status and a general awareness of the medical and sanitary problems of the area. The Whitechapel guardians more liberal attitude to the non-problematic poor did not prevent problems from occurring. When in 1856 they were informed that their fever and sick wards were in a 'very dilapidated' state, they were quick to respond.<sup>157</sup> This was repeated in 1866 when Farnall inspected the Union's homeless poor wards and found them unsatisfactory, saturated with rain due to a bad roof. The guardians were persuaded as a result to provide new wards with 84 beds at a cost of £2,500.<sup>158</sup> The Poor Law Board was pleased with the 'readiness of the guardians to consider the suggestions of Mr Farnall as to remedying any inconvenience suffered by the inmates of the workhouse'.<sup>159</sup> An affront to the guardians' work did much to spur them into improvement and better provision. It was the pressure of information, with 237 letters to the Whitechapel Union in 1866 and 25,608 orders issued by December 1890, and the fact that the central board had to approve all the guardians' activities, that often did more to further policy than any direct measure.<sup>160</sup>

Influence was rarely one sided. Guardians seldom submerged themselves in the basic tenets of policy. Essentially they focused on the mundane matters of the day-to-day administration and jealously defended local autonomy. The central board did its best to implement its directives, but authority was continually modified at a local level. In 1852 the Poor Law Board informed the Whitechapel guardians that an outdoor labour test should be enforced. The guardians protested with other metropolitan unions and their collective intransigency saw a modification of the Order to produce a more lenient policy, giving individual unions more choice.<sup>161</sup> In response the Whitechapel guardians stopped

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<sup>156</sup> J.Brand, *Doctors and the State* (Baltimore, 1965), 90-91.

<sup>157</sup> Whitechapel Archive, Correspondence, Wh/107/9.

<sup>158</sup> Whitechapel Archive, Correspondence, Wh/107/14.

<sup>159</sup> Whitechapel Archive, Guardians' Minutes, Wh/31.

<sup>160</sup> Whitechapel Archive, Correspondence, Wh/107/14; Correspondence, Wh/107/38.

<sup>161</sup> Whitechapel Archive, Correspondence, Wh/107/7.

giving relief to those engaged in trade. Equally the 1879 Notification of Diseases Act was accepted in principle but altered in practice, as the guardians ensured that their medical officers only reported those cases that did not have adequate isolation facilities.<sup>162</sup> They were playing on the middle-class attitudes to the legitimate boundaries of state responsibility and concerns about state invading the individual's home. It also followed a long line of protest over the building of hospitals for infectious diseases.<sup>163</sup> Provision in the Whitechapel Union was continually adapted by the guardians' conception of their own peculiar local circumstances. This view was shared by many other localities, accounting for the gradual adoption of the Metropolitan Poor Act which was initially seen as 'arbitrary, uncalled for and unconstitutional'.<sup>164</sup> The central authority recognised that a too rigid insistence on the letter of the Poor Law would merely provoke a reaction and a return to the obstructionism of the late 1830s and early 1840s.<sup>165</sup> Often the central authority was willing to defer to local judgements and was hesitant to carry out new measures that would fail to secure local support. Inspectors generally held the local situation in mind when making their recommendations. The main priority was to preserve legitimacy and acceptability and this not only meant a cautious policy but also one of compromise.<sup>166</sup> The Select Committee on Poor Relief admitted that 'the guardians should within certain limits be able to adapt their policy to the particular circumstances of each district'.<sup>167</sup> It was the exact nature of these limits that the central board and local guardians contested.

The Whitechapel guardians readily invoked the central authority's own language of expenditure to frustrate orders and legislation. In 1860 they opposed the Medical Relief Bill ostensibly because they felt that it would increase expenditure. In reality they

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<sup>162</sup> Whitechapel Archive, Correspondence, Wh/107/29.

<sup>163</sup> See Ayers, *England's First State Hospitals*.

<sup>164</sup> Whitechapel Archive, Guardians' Minutes, Wh/42.

<sup>165</sup> See N.C.Edsall, *The Anti-Poor Law Movement 1834-44* (Manchester, 1971); Pickstone, *Medicine and Industrial Society*, 91-4.

<sup>166</sup> Bellamy, *Administering Central-Local Government Relations*, 149.

<sup>167</sup> SC on Poor Relief, x.

believed that the bill was ill-suited to London and disliked the fact that the power to grant relief was to be extended, diluting their authority.<sup>168</sup> The 1875 Poor Removal Bill was opposed in a similar vein. It was understood that the measure would 'largely increase pauperism' and 'impose upon them a serious and undue burden of maintenance'.<sup>169</sup> No comparable attempt was made to resist a rise in expenditure as a result of the superannuation clause of the 1864 Poor Law Act, though in 1871 the Whitechapel guardians disagreed with the petition of the National Association of Poor Law Officers that this should be administered centrally.<sup>170</sup>

As a clear statement of policy the 1888 Casual Poor Act was openly resisted. Vagrancy remained a perennial problem for the Poor Law and while administrations could claim numerous achievements, including a dramatic reduction in pauperism, vagrancy stubbornly refused to conform to expectations.<sup>171</sup> Legislation was often at first vigorously enforced, followed by laxity which itself promoted more repressive action. Here the Union's localism was at its most forceful as the Act's provisions were never fully adopted. According to Vorspan, vagrancy reform constituted a rejection of the supposedly inviolable Poor Law principles of local financing by imposing increased expenditure and an imposition of central policy.<sup>172</sup> The Whitechapel guardians were sympathetic to the need to limit the number of casual poor, but found it difficult to accept any Act that encouraged increased spending and central control. They expressed their opposition in terms of the 'considerable increase of expenditure from the Poor Rate of the Metropolis in the provision of further accommodation for vagrants'.<sup>173</sup> In this the guardians had the firm support of the ratepayers. It marked the first part of the Whitechapel's campaign against the casual poor. The desire to limit expenditure, especially when centrally

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<sup>168</sup> Whitechapel Archive, Guardians' Minutes, Wh/27.

<sup>169</sup> Whitechapel Archive, Guardians' Minutes, Wh/107/23.

<sup>170</sup> Whitechapel Archive, Guardians' Minutes, Wh/35; Correspondence, Wh/107/19.

<sup>171</sup> R. Vorspan, 'Vagrancy and the New Poor Law in Late-Victorian and Early Edwardian England', *English Historical Review*, 92 (1977), 59.

<sup>172</sup> Vorspan, 'Vagrancy', 64.

<sup>173</sup> Whitechapel Archive, Guardians' Minutes, Wh/65.

imposed, provided the external reason for dissent, but underneath it was informed by the guardians' conception of pauperism and the necessary solutions to reduce its extent. A firm policy of 'less-eligibility' with a rigid enforcement of a task of work was the guardians' solution and they did their best to circumvent the Act's provisions, imposing longer hours of detention against the Local Government Board's wishes.

The guardians were more effective in persuading the central board to accept their choice in candidates in appointments to Poor Law posts. This is where the ritual dance of authority was elevated to its highest level. Applications followed a prescribed form. The guardians would inform the central board of a resignation, then select a candidate for replacement, and tell the board of their decision. The central board would then ask for further details, negotiate the salary, and confirm the position always making an attempt to accommodate itself to the guardians' wishes. In 1874 the Local Government Board felt uneasy over Ellen Wilson's appointment as a nurse in the Whitechapel Union, partly because they had heard claims that she was unkind. The guardians dismissed this, and the Board gave its approval, though not without reservations.<sup>174</sup> Salary negotiations could be protracted and the guardians gave little ground. When the Poor Law Board complained that the proposed salary increases to the master and matron were higher than the metropolitan average in 1852, the guardians acknowledged their request and ignored it. The Board failed to take any further action.<sup>175</sup> When a new night porter was appointed in 1873 the guardians initially proposed a salary of £1 5s per week. The Local Government Board thought this was too high, and after two months of negotiations a figure of £1 3s was reached.<sup>176</sup> The central authority's position was at its most precarious over appointments as to obstruct the guardians, rather than displaying their dissatisfaction and concern, would have meant a direct challenge to local authority. On some matters it was easier for the central board to back down and save its influence for more important issues. It is likely that the Whitechapel guardians recognised this and moderated or asserted their own position accordingly.

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<sup>174</sup> Whitechapel Archive, Correspondence, Wh/107/22.

<sup>175</sup> Whitechapel Archive, Correspondence, Wh/107/7.

<sup>176</sup> Whitechapel Archive, Correspondence, Wh/107/21.

#### 4. CONCLUSION

The jealousy and impatience of state control had been largely dissipated within Whitechapel Union by the 1870s. The Poor Law Commissioners had struggled with the guardians to implement provision and provide a workhouse, but by the building schemes of the Local Government Board the Whitechapel Union was more inclined to follow central initiatives. In many respects the Whitechapel Union even managed to outpace the Local Government Board's attitude towards relief, making the Union a model administration, but not one beyond truculence. Perhaps because it followed the state's ideas on outdoor relief, it was less inclined to adopt other measures that conflicted with local attitudes to relief. Where the central board could use finance as a restriction on action, or conversely as a lever for policy, its influence was at its most extensive. To achieve a full adoption of policy, however, finance had to be combined with more permanent conceptions of relief and attitudes to pauperism. Where this financial imperative was lacking, the board had to employ other methods that were not always as effective.

The centralisation of services and administration 'applies more accurately to Poor Law theory than to Poor Law practice'.<sup>177</sup> Only over vaccination did the government and the central board force a system in the face of *laissez faire* attitudes and notions of decentralisation, contrasting with the general indifference in other areas of health. Even here, once the fears surrounding smallpox began to decline in the 1880s the system reverted to one of local initiative and began to break down.<sup>178</sup> Gutchen sees that centralisation was not so much apparent in the administration, more in the imposition of national standards and a uniform Poor Law.<sup>179</sup> The pace in the uniform the metropolitan Poor Law was set by the local Board of Guardians, not by the central authority.

The 1860s marked a watershed in the metropolitan Poor Law. This decade saw a strengthening and remodelling of the system, rather than accelerating its demise into

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<sup>177</sup> Vorspan, 'Vagrancy', 61.

<sup>178</sup> R.Lambert, 'A Victorian National Health Service: State Vaccination 1855-1871', *Historical Journal*, 5 (1962).

<sup>179</sup> Gutchen, 'Local Improvements', 86.

state welfare provision as other writers have described. After 1867 there was a move to reestablish the ideas that the 1834 Act and the local boards had failed to implement. Pauperism and expensive outdoor relief once more became the concerns of the administrators as they were enthused by the old ethic in a new guise. They ineffectively replaced the lenient system of outrelief with the more expensive one of institutional care for the non-problematic poor. By the 1900s the main problem of Poor-law administration had become one of finance, with development limited not so much by ethic of 1834, but by the growing cost-consciousness of local ratepayers.<sup>180</sup> The financial problems of the 1900s had already been seen in the late-Victorian period where the answer had been more than the 'piecemeal' concessions Jose Harris has identified.<sup>181</sup> Development between 1850 and 1898 had seen an escalation in expenditure causing a partial revision of the structure of Poor-law finance as new sources of funding were provided. Institutional expansion holds the key both to this diversification of income and the increase in expenditure. At the same time, London's hospitals were experiencing similar pressures on their finances. However, in the metropolitan Poor Law expansion also demanded more precise central influence to ensure that these ideas were adopted, a move that was staunchly resisted in the voluntary sector. This linked finance with authority, and provided the ground on which the local and central administration struggled to ensure that their own conceptions prevailed. Ultimately it was the central board that provided the direction and the income to achieve this transformation, but it was the local Boards that set the pace and established the facilities within their own understanding of what relief entailed. Among these metropolitan boards, the Whitechapel Union was one of the most responsive and the most repressive, but it hardly provided the forerunner of a welfare state open to all.

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<sup>180</sup> N.McCord, 'Ratepayers and Social Policy' in P.Thane (ed.), *The Origins of British Social Policy* (1978), 21-35.

<sup>181</sup> Harris, 'Transition to High Politics', 75.



## **Part IV: 1897 and Beyond**

## State Aid Versus Voluntarism

In 1897 the British Empire celebrated Queen Victoria's Diamond Jubilee with all the pomp and pageantry that it could muster. 1897 also represented a significant year for charity and the Jubilee was zealously exploited by philanthropists who used it as an excuse to launch new appeals.<sup>1</sup> Hospitals benefited from the patriotic upsurge in benevolence, but the foundation that year of Prince of Wales Hospital Fund as a commemorative fund had a greater impact. The Golden Jubilee had set the precedent, inaugurating an appeal to support district nursing, while the Sunday Fund and Saturday Fund had established a model of indirect philanthropy that the new fund copied. However, the Prince of Wales Hospital Fund represented a subtle transformation in the nature of hospital philanthropy. It reaffirmed the hospitals' voluntary nature in an attempt to resolve their financial problems and prevent state intervention.

### 1. HOPES AND FEARS OF STATE INTERVENTION

From the 1880s onwards an increasingly pessimistic assessment of the London hospitals' financial position came to dominate views on hospital funding. By 1887 latent concerns had been replaced by widespread anxiety. Dr Gilbert Smith expressed a common opinion when he told the Select Committee on Metropolitan Hospitals in 1890 that 'the funds now available either for the proper maintenance of nearly all the existing [medical] institutions, or for the extensive relief to districts hitherto unprovided for, are insufficient'.<sup>2</sup> Few governors shared Henry Burdett's optimism when he countered statements in *The Times* in 1894 that charity was '*in extremis*'; they believed that their institutions were sinking further into debt.<sup>3</sup> The Sunday Fund added to these fears in recognition of its own financial inadequacy when it admitted that at least £100,000 was needed per annum to

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<sup>1</sup> Among these was such large national charities as the NSPCC: G.K.Behlmer, *Child Abuse and Moral Reform in England 1870-1908* (Stanford, 1982), 143.

<sup>2</sup> SC of the House of Lords on Metropolitan Hospitals, 1st Report, *PP* 1890 XIX, 15.

<sup>3</sup> *Times*, 25 December 1894, 9.

cover the hospitals' deficit. Debt was not universal, but the image projected by the precarious economic position of Guy's, St. Thomas's, King's College Hospital, and University College Hospital seemed to presage a general crisis. As these hospitals were among London's leading medical institutions, concerned contemporaries wondered what hope there was for smaller hospitals, though ironically these were in a better financial position.

An almost universal belief that London's hospitals were facing an endemic financial crisis was translated into apprehension that the state might have to intervene. As early as 1881 Burford Rawlings, secretary to the National Hospital for the Paralysed and Epileptic, had predicted the inevitability of state intervention.<sup>4</sup> In the following year these fears had started to enter the vocabulary of the hospitals' appeals. At University College Hospital's annual dinner in 1882, the Earl of Kimberley warned that because of the 'unsatisfactory basis' of most metropolitan hospitals' finances voluntary effort would have to be bolstered by state subsidy.<sup>5</sup> In 1883 the *Charity Record & Philanthropic News* and *The Times* expressed similar concerns, noting that state assistance might be essential to prevent the collapse of the voluntary medical system.<sup>6</sup> Concerns about the possibility of state intervention increased with the hospitals' deepening economic crisis. In 1887 the Bishop of London expressed a common feeling among governors that the spectre of public assistance was looming.<sup>7</sup> When several hospitals, including Guy's and University College Hospital closed wards, the collapse of the voluntary system seemed only a matter of time. Few contemporaries shared Morley's stoicism when he stated that he was prepared to see such a move rather than see hospitals close.<sup>8</sup>

The recurrent fears of state intervention in the London hospitals from the early 1880s onwards did not match continental experiences. In many European countries and

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<sup>4</sup> B. Burford Rawlings, 'The Honorary Element in Hospital Administration', *Fraser's Magazine*, 24 (1881), 67.

<sup>5</sup> *Lancet*, 1 (1882), 315.

<sup>6</sup> *Charity Record & Philanthropic News*, 3 (1883), 28; *Times* 20 January 1883, 9.

<sup>7</sup> *Times*, 13 June 1887, 14.

<sup>8</sup> *Charity Record & Philanthropic News*, 6 (1886), 37.

in America the state played an acceptable and integral role in the provision of public and voluntary healthcare. The two were not often separated. In France, a state directed and partially funded system had existed in Paris since the formation of the Hospital Council of the Seine Department and the *assistance publique* in the 1797. The Revolution had confiscated Church property and removed the emphasis on private and religious benevolence. With the growth of an idea of participatory citizenship and equality, healthcare was made into a right organised by the state, not a function of charity.<sup>9</sup> The transition met with opposition, but by 1851 communes were obliged to take responsibility for the sick poor. In Paris the *assistance publique* received part of its income from a municipal grant; the rest from the accumulated wealth of charitable bequests.<sup>10</sup> Though the emphasis on healthcare changed between the Restoration and the Third Republic, the state retained its influence and in 1893 passed national medical assistance legislation creating a different path to state medical welfare than that offered under the Bismarckian social insurance provisions of the 1880s.<sup>11</sup> In America, the state equally played an active role, but was more concerned with funding than with direct organisation.<sup>12</sup> State intervention in Pennsylvania was not unique: by 1910 141 of the 167 hospitals in the state received a grant.<sup>13</sup> Intervention followed no predetermined strategy and was seen as a natural function of government. The Civil War had increased demands for hospital care and mixed private and public initiatives that continued after the war. The result stimulated the growth of voluntary hospitals. Corporate expenditure on hospitals was seen as having material and palliative benefits for business minded officials, but philanthropists remained in control and calls in the 1890s for more local control were ignored.<sup>14</sup> In

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<sup>9</sup> D.Weiner, *Citizen-Patient in Revolutionary and Imperial Paris* (1993).

<sup>10</sup> P.Weindling, 'The Modernisation of Charity in Nineteenth Century France and Germany' in J.Barry & C.Jones (eds.), *Medicine and Charity Before the Welfare State* (1994), 192-3.

<sup>11</sup> E.B.Ackerman, *Health Care in the Parisian Countryside 1800-1914* (1990).

<sup>12</sup> See M.J.Vogel, *Invention of the Modern Hospital* (Chicago, 1980).

<sup>13</sup> R.Stevens, 'Sweet Charity: State Aid to Hospitals in Pennsylvania 1870-1910', *Bulletin of the History of Medicine*, 58 (1984), 288-9.

<sup>14</sup> Stevens, 'Sweet Charity', 311-13.

America, philanthropy could co-exist with state assistance and limited government demands without a challenge to the hospitals' voluntary nature.

In Britain the situation was different. The state, through Sir John Simon's work at the Privy Council and then under the Local Government Board, was willing to give small grants towards medical research. Intervention was limited: the first Auxiliary Scientific Grant of £2,000 was awarded in 1871, and support was seen as part of the public health initiative.<sup>15</sup> Medical care in an institution partly funded by charity, however, was a different issue. The reasons might be found in the ingrained nature of voluntarism, support for the idea of a limited state, and hostility to state action, which was not compensated for by a medical profession geared to market forces and research. Hospital governors, like the mass of the subscribing public, remained hostile to state intervention and unaffected by the growing arguments in favour of state action.<sup>16</sup> Many viewed the state in terms of centralisation and any growth in its power was seen as an attack on the 'spontaneous efforts of individuals or voluntary groups'.<sup>17</sup> Hospital philanthropists appeared more dogmatic in their antipathy to state intervention than other philanthropists in a climate where the state's role in social welfare increasingly came under discussion from the 1880s onwards. However, primary healthcare was set apart from these debates. Despite the expansion of the metropolitan Poor Law's medical services which increased the complexity of the London medical market, few discussed the relationship between the London hospitals and the state because it appeared an unlikely and unwelcome partnership.

A similar reluctance to intervene in the voluntary provision of primary healthcare was shared by the state. A faith in minimal government joined with the Gladstonian belief that charity had an important role to play in welfare, helped ensure that no Victorian government was willing to interfere with the voluntary healthcare. The public health movement, expanding Poor-law medical services, and the development of the MAB

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<sup>15</sup> T.Stourkes, 'John Simon, Robert Lowe and the Origins of State-Supported Biomedical Research in Nineteenth-Century England', *Journal of the History of Medicine*, 48 (1993).

<sup>16</sup> See J.Harris, 'Political Thought and the Welfare State 1870-1940', *Past and Present*, 134/5 (1992) and S.Collini, *Public Moralists* (Oxford, 1991).

<sup>17</sup> S.Collini, *Liberalism and Sociology: L.T.Hobhouse and Political Argument in England 1880-1914* (Cambridge, 1979), 23.

created an alternative arena of state interest in healthcare for those classes that the London hospitals did not claim to assist. However, the state did have an indirect effect. For example, the changes made in the local taxation system burdened hospitals' precarious financial position. Charitable institutions had been excluded from imperial taxation, but Gladstone threatened their right to tax exemption in 1863 and in 1866 a court decision in Liverpool made them liable for local rate assessment. The decision in Liverpool had national implications, forcing hospitals to contribute towards the poor rate and sponsored a periodic and unsuccessful reform movement to reverse the decision.<sup>18</sup> It was not until 1875, once the City of London had effectively established St. Thomas's rate liability, that the London hospitals were included and in response governors enthusiastically joined the rating exemption campaign.<sup>19</sup> Predictably this new taxation incensed vested interests and did nothing to enhance governors' opinions of the state.

Antipathy to state intervention in the London hospitals was not total and debate existed in a muted form. It was part of a wider discussion on the role of the state and new attitudes to welfare. According to Thane, 'the problem that was increasingly evident by the 1890s was that for all the high-minded principles underlying the Victorian consensus on the minimal state, the liberal economy, decentralisation, probity in public life and the responsible involvement of the citizenry, serious social problems visibly remained'.<sup>20</sup> A renewed awareness of poverty showed that charity was not enough and philanthropists found themselves increasingly prepared to encourage legislation where individualistic efforts had failed.<sup>21</sup> At an intellectual level, liberal theorists proposed a changing conception of the state as an agent of communal responsibility.<sup>22</sup> These arguments joined with practical developments. Outside healthcare, the state was beginning to take a more active role in social policy and by the 1890s these concerns had

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<sup>18</sup> D.Owen, *English Philanthropy 1660-1960* (Cambridge, 1964), 341-343.

<sup>19</sup> *Charity*, December 1889, 169.

<sup>20</sup> P.Thane, 'Government and Society in England and Wales' in F.M.L.Thompson (ed.), *Cambridge Social History of England 1750-1950*, 3 (Cambridge, 1990), 48.

<sup>21</sup> Collini, *Liberalism and Sociology*, 23.

<sup>22</sup> See Harris, 'Political Thought and the Welfare State', 116-41.

started to become issues of 'first-rate national importance'.<sup>23</sup> By 1914 the approach to social policy had profoundly changed and government felt forced to resort to an interventionist role, partly because politicians had come to believe that voters were motivated by social welfare issues. Under these conditions the boundaries between the state and charitable provision were re-negotiated, but charity continued to maintain an active role.<sup>24</sup> Progressive hospital reformers were part of this development and from the 1880s onwards they began to question the voluntary system and see a role for the state in healthcare beyond the Poor Law. Two strands emerged in the debate, one linked to finance, the second rooted in the need to promote coordination between healthcare sectors to solve the problems of institutional overcrowding in north London. Where both the Duke of Devonshire and Roberts in *Public Control of Hospitals* advocated state support because hospitals were a public utility like gas and water, few other explicit references connected London's hospitals to municipal socialism.<sup>25</sup> It was state intervention, not local control that was feared and discussed. The impetus came mainly from a concern that hospitals faced mounting debt and this was linked to an awareness that reforms could no longer be avoided.

A rate supported scheme had been suggested in 1858, but Burdett was one of the first hospital reformers to discuss the boundaries between the state and voluntary hospitals.<sup>26</sup> In *Hospitals and the State* he argued that hospitals were in urgent need of reform and in a later article in *Nineteenth Century* he called for parliamentary action to encourage reorganisation. However, Burdett avoided the need for state intervention by calling on the Social Science Association to take an active role in hospital reform.<sup>27</sup> Gilbert Smith, at the Social Science Association's annual conference in 1882, returned to the issue and at the 1883 conference Frederick Mouat's proposals for an integrated health

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<sup>23</sup> Cited in Harris, 'The Transition to High Politics', 61.

<sup>24</sup> See G.Finlayson, *Citizen, State, and Social Welfare in Britain 1830-1990* (Oxford, 1994).

<sup>25</sup> *BMJ*, 2 (1892), 964; H.Roberts, *Public Control of Hospitals* (1895), 3.

<sup>26</sup> *Medical Times & Gazette*, 37 (1858), 104.

<sup>27</sup> H.C.Burdett, *Hospitals and the State* (1881); 'Our Hospitals', *Nineteenth Century*, 13 (1883).

service were discussed in detail. After two years of discussion a conference of hospital governors was called, out of which the Hospital Association was formed.<sup>28</sup> It was anticipated that the new Association would be a voluntary alternative to state action, but it did little to end the discussion over state intervention. Few schemes were discussed as extensively as Dr Robert Rentoul's. In 1889 Rentoul launched a vitriolic attack on the outpatient system which he claimed was the subject of flagrant abuse by the middle classes. He argued that medical relief within the non-endowed hospitals was inadequate and public recognition of this had led to a fall in income. Rentoul believed that a 'public medical service' would solve all the hospitals' problems.<sup>29</sup> The medical journals attacked Rentoul's ideas and a lively debate was stimulated on the possibility of a wholly state coordinated or organised scheme. In response the BMA appointed a special committee in 1890 to investigate. The doctors consulted by the BMA expressed a need for reform, but Rentoul's ideas aroused fears that a government body would reduce fees and a clear majority rejected the scheme as impractical and undesirable.<sup>30</sup> In such a climate Rentoul's ideas were discredited, but they had helped to generate debate. Simultaneously Rentoul's work encouraged others, like Sutherland, medical officer of Glasgow prison, to adopt a similar frame of reference when discussing the future of hospital funding.<sup>31</sup>

Mounting pressure from the COS, the Hospital Association and the press for reform forced a situation where the state had to take an active interest in the voluntary system, if only to defend it.<sup>32</sup> Where reformers and the government would not contemplate state intervention, both gradually accepted the need for a parliamentary inquiry. As early as March 1879, discussions were initiated by Fowell Buxton, chairman of the London, for a select committee, but no coherent plan emerged. According to the

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<sup>28</sup> M.Millman, 'The Influence of the Social Science Association on Hospital Planning in Victorian England', *Medical History*, 18 (1974), 128-132.

<sup>29</sup> *BMJ*, 2 (1880), 1067.

<sup>30</sup> J.Brand, *Doctors and the State* (Baltimore, 1965), 154.

<sup>31</sup> *Hospital*, 2 March 1889, 342.

<sup>32</sup> Hospitals were not the only philanthropic object that underwent investigation in the 1890s as the NSPCC in 1895-6 and the RNLI in 1897 were exposed to searching inquiries and then vindicated: Behlmer, *Child Abuse*, 145-149.



*BMJ* fear of state control or ‘something of this sort’ had retarded ‘the movement in favour of a public inquiry...’. The journal itself and many hospital reformers supported a royal commission in the hope that it would ‘educate the public into recognising the public importance of voluntary hospitals’ and stimulate charity.<sup>33</sup> Sir William Harcourt, the Chancellor, had acknowledged the need for an inquiry following the nursing dispute at Guy’s, but public interest was not stimulated until 1888 when the COS took up the issue as part of its campaign to organise charity.<sup>34</sup> Aware of its unfavourable image, the COS was careful to explain that it did not wish to discredit the voluntary system, only to promote ‘some improvement in their organisation that will make them [the hospitals] even more useful than they are now’.<sup>35</sup> With the support of leading hospital governors and elements in the medical profession, the COS circulated a petition which Lord Sandhurst presented to the Lords in July 1889. The BMA welcomed the initiative; for its part the Hospital Association was antagonistic but realistic enough to claim some credit for creating a climate of opinion that favoured reform.<sup>36</sup> Burdett saw the approach as destructive and maintained that the inspiration had come from ‘disaffected persons with axes to grind’, but his protests did nothing to alter the situation.<sup>37</sup> As governors were sensitive to a royal commission, Lord Cranbrook, the minister responsible, decided upon a select committee.

The House of Lords’ Select Committee on Metropolitan Hospitals met under the chairmanship of Sandhurst from 1890 to 1892. The long duration of the inquiry was testimony to the complexity of the issues involved. The press responded with extensive coverage of the Committee’s proceedings, and time was wasted discussing the intricacies of nursing at the London and the sanitary arrangements at St.Bartholomew’s. From the beginning the Committee recognised that state interference was incompatible with the principle of voluntarism and completely vindicated the existing system in its final report

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<sup>33</sup> *BMJ*, 2 (1881), 87.

<sup>34</sup> See pages 239-50 for a discussion of the nursing dispute.

<sup>35</sup> SC on Metropolitan Hospitals, 1st Report, 6.

<sup>36</sup> FWA Archive, C/A26/9.

<sup>37</sup> G.Rivett, *Development of the London Hospital System* (1986), 135.

in 1892.<sup>38</sup> *The Times* felt that the committee had been appointed with this purpose in mind, 'to furnish the Government with good reasons for leaving the hospitals alone'.<sup>39</sup> Ultimately it made weak recommendations, but proposed a modicum of informal centralisation. The COS was disappointed, but believed that the final report was 'as good as could be expected from a body of amateurs...'.<sup>40</sup> Others were more enthusiastic because the Lords' unqualified support of voluntarism seemed to place the emphasis firmly on reform within a voluntary context and remove any threat of state intervention.

The dismissal of Rentoul's 'public medical service' and the Select Committee's final report did not, however, end debate. The Lords had supported the voluntary system, encouraged nursing reform at the London and sanitary improvements at St.Bartholomew's, and relieved public pressure for action, but it had done nothing to solve the problems facing London's hospitals. Progressive reformers therefore continued to see a role for the state. In 1892 Mathers and Sydney Buxton introduced a private members bill to allow local authorities to support voluntary hospitals and have full subscribers' rights.<sup>41</sup> The bill partly recognised that Poor-law guardians and municipal authorities already subscribed to specialist hospitals and sent patients to general hospitals for treatment that they could not provide.<sup>42</sup> The bill received no discussion and did not have a second reading. Jackson, when questioned over the possibility of a grant to the hospitals in Belfast, indicated the general feeling of the House towards state assistance. He noted that 'I am not aware of any proposal to make grants from public money to the hospitals in Belfast or in other cities in the United Kingdom, nor even if such a proposal were made do I think it would meet the approval of the House'.<sup>43</sup> Mathers and his colleagues were discouraged by such statements and let the bill drop, but interest in state intervention resurfaced in 1896. Knowsley Sibley, in *State Aided v. Voluntary Hospitals*, called for a state medical service

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<sup>38</sup> SC on Metropolitan Hospitals, 1st Report & 2nd Report, *PP* 1890/1 XIII.

<sup>39</sup> Cited in *BMJ*, 1 (1893), 30.

<sup>40</sup> *Charity Organisation Review*, January 1893, 28.

<sup>41</sup> *Hansard* (H of C), 10 February 1892, col. 106.

<sup>42</sup> *Times*, 19 March 1892, 5.

<sup>43</sup> *Hansard* (H of C), 15 February 1892, col. 448.

and pointed to a current of opinion favouring reorganisation.<sup>44</sup> James Erskin, in 'A Plea for A State Medical Service', proposed a similar scheme.<sup>45</sup> Few, however, were prepared to go as far as Colonel Gordon Wilson in suggesting a 1d. levy on income tax to replace benevolence.<sup>46</sup>

The press debated the merits of these schemes in a critical light, but even the more sympathetic felt that hospitals could not be surrendered to 'economy and political expediency'.<sup>47</sup> Erichsen, chief surgeon at University College Hospital, believed that state support would 'dry up' charity and multiply the very problems it sought to solve.<sup>48</sup> Hospital reformers warned that any form of state subsidy would inevitably lead to a demand for representation and ultimately to state dominance, manipulating public prejudice against intervention. The public was more critical. Cherry believes that the state's role in providing healthcare was seen as 'minimal or indeed undesirable by most sections of society'.<sup>49</sup> Many claimed that such support was morally objectionable and went against an ethic of voluntarism that was an integral part of the social fabric. In their defense of voluntarism they appeared to forget the philanthropic chaos that the COS had highlighted. The *Hospital* shared this opinion, but warned governors that they should take note of the developments in education.<sup>50</sup> Governors and hospital reformers certainly feared the possibility of state intervention and constantly used it in the 1890s as a shibboleth to invoke public support. Two movements emerged from these concerns as voluntary alternatives to state funding and organisation. The foundation of the Prince of Wales Hospital Fund in 1897 and the Central Hospitals' Council for London in the following year saw the embodiment of reformers' hopes that a voluntary means could be

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<sup>44</sup> *Lancet*, 1 (1896), 723.

<sup>45</sup> *Charity Record & Philanthropic News*, 17 (1897), 335.

<sup>46</sup> *Lancet*, 1 (1896), 723.

<sup>47</sup> *Hospital*, 12 December 1896, 175; 3 October 1896, 15.

<sup>48</sup> *Charity Record & Philanthropic News*, 15 (1895), 90.

<sup>49</sup> S.Cherry, 'Beyond National Health Insurance. The Voluntary Hospitals and Hospital Contribution Schemes: A Regional Study', *Social History of Medicine*, 5 (1992), 456.

<sup>50</sup> *Hospital*, 26 November 1892, 130.

found to solve the problems of finance and organisation that would permanently remove the need for state intervention. The foundation of these two bodies served to check the debate over the role of the state until the issue reemerged during the 1905-9 Royal Commission on the Poor Law.

## 2. THE PRINCE OF WALES HOSPITAL FUND

The Prince of Wales Hospital Fund (later known as the King's Fund) built on the fashionable awareness that London's hospitals faced a financial crisis that would ultimately lead to state intervention unless an alternative remedy was found. The recent successes of the Sunday Fund in 1895 and the launch of an endowment appeal by Guy's in 1896 only seemed to confirm charity's strength. Given the hospitals' structure of income, the faith was ultimately misplaced. The Prince of Wales Hospital Fund stood at the intersection of opposition to state funding initiatives and the perceived need to place the capital's hospitals on a firm financial footing with a guaranteed source of income.<sup>51</sup>

James Erskin's awareness that the Prince of Wales Hospital Fund was an attempt to prevent state intervention was shared by its founders.<sup>52</sup> Introducing the appeal, the Prince stated that

public opinion has shown itself on more than one occasion, and I think wisely, in favour of the voluntary system for support for our hospitals, combined with an adequate system of representation of the body of subscribers in their control and management. It is obvious, however, that if these institutions are to be saved from the state or parochial aid, their financial condition must be secured.<sup>53</sup>

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<sup>51</sup> For a recent history of the Fund see F.K.Prochaska, *Philanthropy and the Hospitals of London* (Oxford, 1992) who offers a meticulous account of the Fund's confused genesis, highlighting the crucial role played by Burdett and the Prince's enthusiasm for medical charity, a royal link that was constantly exploited, providing one of the main reasons for the Fund's success long after the Jubilee excitement had waned

<sup>52</sup> *Charity Record & Philanthropic News*, 17 (1897), 335.

<sup>53</sup> King's Fund Records, Greater London Records Office (hereafter KF Archive), 1897 Annual Report, KE/300/1.

The Sunday Fund had attempted to resolve this dilemma, but its interventionist aims had been submerged beneath the practicalities of administering general maintenance grants. The Prince of Wales Hospital Fund built on the Sunday Fund's experiences and attracted many of its supporters. It adopted the contemporary analysis that an additional assured income of £100,000 was needed per annum to prop up the voluntary system and ignored suggestions that rationalisation might solve the hospitals' problems. No attempt, however, was made to account for rising expenditure or institutional expansion which would only multiply the existing problems the Fund sought to solve. The Sunday Fund had shown that there was a limit to the amount that could be raised annually so the Prince of Wales Hospital Fund adopted the controversial policy of endowment, a policy that reflected the Prince's opposition to annual appeals. By December 1897 the optimism placed in endowment had receded as the Fund's organisers realised that the endowed income could initially only raise £5,000 and the anticipated annual income of £100,000 was not reached until 1909.<sup>54</sup>

According to Prochaska, 'in a society fascinated by the royal family, and with an increasing demand for hospital provision, the Fund had every hope of success'.<sup>55</sup> Contemporaries viewed the £227,551 12s 5d collected in 1897 as an undoubted success and for one enthusiast in the *Hospital*, it had ended the 'days of doubt'.<sup>56</sup> However, many voiced disappointment that more had not been accomplished. The *BMJ*, *The Times* and the COS had predicted in 1897 that the Fund would have problems after the Jubilee and this was borne out by the dramatic fall in revenue after 1897, as 'enthusiasm, even when most glaring, is not always convertible into a satisfactory equivalent in cash'.<sup>57</sup> Dissatisfaction increased between 1898 and the coronation in 1902 because collections remained modest in comparison to 1897. Disappointment and the fall in the amounts collected after 1897 conceal the Fund's impact. The Jubilee collection was the largest single amount raised in any one year for the London hospitals, and in the following years

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<sup>54</sup> Prochaska, *Philanthropy and the Hospitals*, 34-39.

<sup>55</sup> Prochaska, *Philanthropy and the Hospitals*, 23.

<sup>56</sup> *Hospital*, 20 February 1897, 341.

<sup>57</sup> *BMJ*, 1 (1897), 413.

the Fund provided a welcome source of funding. It also symbolised a new departure in fundraising, exploiting the traditional modes of direct philanthropy and adding its own innovative tactics.



Source: Rivett, *Development of the London Hospital System*, 147.

Previous benevolent funds had attempted to extend charity beyond the traditional subscribing public and the Prince of Wales Hospital Fund tailored its appeal to this purpose, '...to both great and small, private individuals and capitalist organisations'.<sup>58</sup> Burdett, as one of the Fund's main organisers, recognised that 'money must now be collected not from the few, but from the many, and every one must be interested in the

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<sup>58</sup> *Daily Chronicle*, 6 February 1897, 4.

process' to prevent the voluntary system from collapsing.<sup>59</sup> The aim was to democratise benevolence and ensure that every sector of society contributed. The Fund argued that this would not damage other institutions because these new subscribers had no established tradition of giving, while it would encourage self-help among those who had previously only benefited. Success was not complete. The mass of contributions continued to come from the middle classes, from 'munificent gifts' and from the new plutocracy of businessmen. Only £51 was raised from contributions under five shillings in 1897 and it was felt as early as June that the working and lower-middle classes were failing to support the Fund.<sup>60</sup> The Fund redoubled its efforts, though with little apparent success, and founded the League of Mercy in 1898 to appeal directly to these groups.<sup>61</sup> The Fund's inability to compete with local networks of working-class charity, built on community and familial ties, or rival established provident dispensaries and benefit societies, came from the fact that they offered practical returns where it gave none.<sup>62</sup>

The Fund had difficulty tapping working-class benevolence, but it exploited every charitable imperative and played on guilty consciences, social aspirations, compassion for the sick, and 'love and loyalty to the throne'.<sup>63</sup> No effort, however, was made to capitalise on the imperial federation movement and its concern with 'national efficiency' and latent opposition to state welfare.<sup>64</sup> Little was left to chance and personal contacts

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<sup>59</sup> *Hospital*, 13 June 1896, 181.

<sup>60</sup> *BMJ*, 1 (1898), 1341; *Times*, 10 October 1898, 9.

<sup>61</sup> Like the NSPCC's League of Pity, the League of Mercy intended to bring local traditions of community service to the hospitals' benefit within a hierarchical organisational structure which stressed the reciprocal duties between the hospital and the recipient of medical aid. The League initially faced enormous difficulties and both Loch and Sydney Holland actively resisted it, but the Prince rallied to the idea and after a slow start the movement snowballed, increasing the Fund's prestige and income.

<sup>62</sup> See P.Mandler, 'Poverty and Charity in the Nineteenth Century Metropolis' in P.Mandler (ed.), *The Use of Charity* (Philadelphia, 1990).

<sup>63</sup> Prochaska, *Philanthropy and the Hospitals*, 22.

<sup>64</sup> The King's Fund did not appear to be influenced by these ideas as it failed to adopt the liturgy of imperial federation or national efficiency. Certainly the Fund did aim to promote efficiency and opposed state welfare, but the prominent supporters of these ideas did not form a substantial element in the subscription list. Although Alfred Harmsworth,

were exploited, becoming a hallmark of the Fund's tactics. Collections were not taken on a single day as it was envisaged that the Fund would receive money all year. As such it was more of a charitable society comparable to the COS than a benevolent fund. The mechanisms of direct philanthropy were used to the full, forming the most traditional aspect of its activities. The Fund raised £120,028 11s 10d in 1897 and £32,182 8s 7d in the following year (see table 8.1). Donations were welcomed, but it was subscriptions that were solicited to ensure a reliable income. Such was the confidence expressed in the Fund, that the Trustees of the London Parochial Charities, a body formed to rationalise out-moded posthumous benevolence, contributed £1,000 per annum from 1898 to distribute to convalescent homes.<sup>65</sup> Public subscription lists were analysed and appeals made to those most likely to give, while obituaries were scoured for relatives with money left to undefined charitable purpose.<sup>66</sup> All contributions received a thank-you note; those who gave over £5,000 received personal letters from the Prince, invitations to royal events, or gifts of game from Sandringham. Effort was not only directed at individuals: 28,200 companies were approached in 1897.<sup>67</sup> Banking support was canvassed by Lord Rothschild and 80 direct appeals were issued, though the result was initially disappointing. The Livery companies retreated behind the claim that they already helped individual hospitals, but as the Fund matured they increased their contributions with 21 companies giving £240,000 between 1897 and 1940.<sup>68</sup> It is unlikely that many would have been as generous without the knowledge that the Prince desired it and the recognition or prestige that was gained from subscribing.

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Lord Strafford and Lord Rothschild were all represented on the Fund's management, only Lord Rothschild had an influential role. The presence of such names should not over-ride the view that other charitable motives were more important and such was the nature of the Fund's appeal that the supporters of imperial federation would probably have contributed independently of their imperial ideology: See R.Smith, 'British Nationalism, Imperialism and the City of London 1880-1900' (Unpublished PhD Thesis, University of London, 1985).

<sup>65</sup> KF Archive, 1898 Annual Report, KE/300/2.

<sup>66</sup> KF Archive, Executive Council, KE/27/1.

<sup>67</sup> KF Archive, Executive Council, KE/27/1.

<sup>68</sup> Prochaska, *Philanthropy and the Hospitals*, 28.



Although subscriptions and donations provided the bulk of the Fund's support, they were supplemented by revenue that marked a new departure in fundraising.

Table 8.1: Prince of Wales Hospital Fund Income 1897-1898.

Income	1897		1898	
	Amount	%	Amount	%
Subscriptions	£21,443	9.4	£23,318	59.4
Donations	£98,605	43.4	£8,864	22.6
Legacies	-	0	£10	*
Trustees	-	0	£1,000	2.5
Newspaper Collections	£42,681	18.7	£181	0.5
Mayoress Fund	£5,373	2.4	-	0
Programme Sales	£2,041	0.9	-	0
Hospital Stamps	£34,776	15.3	-	0
Investments	£1,469	0.6	£5,334	13.6
Retained as Capital	£21,161	9.3	£564	1.4
<b>TOTAL</b>	<b>£227,551</b>	<b>100</b>	<b>£39,271</b>	<b>100</b>

\* - the figure for this amount represents 0.03% of the total collection.

Source: KF Archive, Annual Reports, KE/300/1-2.

Investments, which were supposed to furnish the main body of income, initially provided a small percentage. This proportion increased over time, rising in the first two years from 0.6% to 13.6%. It was not, however, until after 1909 that investments attained the position that the founders had intended.<sup>69</sup> The Fund extended the role of endowments from an institutional source of capital to a metropolitan source of revenue as it was hoped that this would provide a permanent solution to debt and offset the need for public assistance. In 1897, 75% of the collection was invested. Thereafter a varying proportion of the collection was invested annually until the target income was reached. The Fund modified the ideas of posthumous benevolence, adopting the hospitals' conception of endowment as a permanent source of funding by using endowed revenue to finance an

<sup>69</sup> KF Archive, Annual Reports, KE/300/1-2.

organisation that would be administered to address the problems of the present rather than the troubles of the past. It was a far-reaching and innovative approach, though one ultimately flawed as it failed to anticipate that expenditure was not static.

The other components of income for the first year were no less innovative, but dwindled after the Jubilee as the Fund became confined to direct philanthropy and endowments. The Jubilee was exploited to the full: Jubilee Procession Programmes were sold and the Lady Mayoress Jubilee Appeal was redirected to hospitals and administered by the Fund. Hospital stamps were designed to recruit small subscribers and were advocated by Burdett who took most of the credit for them.<sup>70</sup> In the first collection they



Source: Rivett, *Development of the London Hospital System*, 149

<sup>70</sup> *Standard*, 4 February 1898, 3.

raised £34,776 5s, accounting for a large proportion of that year's grants. The COS thoroughly disapproved of this means of raising money and claimed that charity should be a sacrifice without reward, but the Fund was aware that subscribers expected something for their money.<sup>71</sup> Unfortunately the stamps' initial popularity was not enough to ensure that they remained a permanent feature. Dedicated philatelists and stamp dealers refused to buy them, and with no commemorative function after the Jubilee or any postal value many subscribers quickly lost interest.<sup>72</sup> As a result they were abandoned. A diverse source of income was not enough to ensure that collections preserved their 1897 level.

Hospital governors complained that the entire 1897 collection had not been directed to resolve their accumulated debts and Sydney Holland, from his desire to maximise the London's income, voiced the concern of the smaller institutions that the distribution was unfair. When the Mary Wardell Convalescent Home in Stanmore, Middlesex, received an unusually large grant in recognition of the Princess of Wales's support for the institution, these criticisms were supported.<sup>73</sup> Distribution was not always perfect, but generally grants were dis-imbursed, as the *Lancet* acknowledged in 1899, with discernment and fairness.<sup>74</sup> Most recognised welcomed the Fund, especially as it could be a generous body: the Hospital for Sick Children was awarded £50,000 in 1902 to build a new outpatients' department. Most grants, however, remained small.<sup>75</sup> For example, in 1898 the Royal Chest Hospital received £100, though the larger hospitals could receive grants of over £5,000.<sup>76</sup> The idea was 'to do the greatest good to the greatest number of the sick, not the greatest good to the greatest number of hospitals'.<sup>77</sup> This conceals the impact of the Fund's grants which on average represented 5% of individual hospitals' income. Institutional experiences differed: for the Hospital for Sick Children the 1899

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<sup>71</sup> *Charity Organisation Review*, 3 (1898), 63.

<sup>72</sup> KF Archive, Press Cuttings, KE/750/10.

<sup>73</sup> Prochaska, *Philanthropy and the Hospitals*, 34.

<sup>74</sup> *Lancet*, 1 (1899), 42.

<sup>75</sup> KF Archive, Report of the Hospital for Sick Children, KE/250/1.

<sup>76</sup> RCH Archive, Annual Report, A8/12; Guy's Archive, 1898 Annual Report, A94/2.

<sup>77</sup> Prochaska, *Philanthropy and the Hospitals*, 52.

grant represented 3.4% of the total income; for Guy's this was 7.7% raising the proportion of the hospital's revenue from charity to 37.2%.<sup>78</sup> Critics, in particular the COS, claimed that the Fund could not increase the aggregate resources available to hospitals, only redirect the income obtainable within the benevolent economy.<sup>79</sup> This was not entirely true. Both the Sunday and the Saturday Fund were indeed damaged by the new movement, despite attempts to limit rivalry and promises that the Prince of Wales Hospital Fund would not trespass on the other funds' territory.<sup>80</sup> Hospitals, however, benefited from the competition and the Fund opened 'new fields of practical benevolence'.<sup>81</sup> In 1897 the income of 93 hospitals showed an increase, and in 1898 ordinary income was £35,000 higher than in 1897.<sup>82</sup> The existence of the Prince of Wales Hospital Fund must account for part of this rise. The effect was to provide a fresh source of charitable income at a time when philanthropists were afraid that the state might have to intervene.

The Prince of Wales Hospital Fund embodied a new opportunity to influence hospitals through financial incentives and as such it received advice from all quarters about how its income should be distributed. Many governors sympathised with Dr Thomas Glover Lyon's view that the Fund should distribute the entire collection rather than 'hoard' the income, but this opinion did not make much headway.<sup>83</sup> The secretary of the Westminster Ophthalmic Hospital, Beatrice Campbell, suggested that the Coal, Corn and Finance Committee of the Corporation of London should be used to distribute the grants.<sup>84</sup> Such an approach through local government was clearly unacceptable because the Fund aimed to uphold charity. The COS urged that the mistakes of the Sunday Fund

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<sup>78</sup> GOS Archive, Miscellaneous Financial Records, GOS/3/4/7; Guy's Archive, 1898 Annual Report, A94/2.

<sup>79</sup> *Charity Organisation Review*, 3 (1898), 63: COS remained a stern critic, disliking the Fund for the attention it had taken away from its own schemes for a central board.

<sup>80</sup> KF Archive, Executive Council, KE/27/1.

<sup>81</sup> *Lancet*, 1 (1897), 1656.

<sup>82</sup> *Times*, 21 December 1898, 8.

<sup>83</sup> *Times*, 23 December 1897, 4.

<sup>84</sup> KF Archive, Correspondence, KE/567.

should not be repeated and the BMA picked up the hidden meaning by proposing that the collection should be distributed publicly through a body similar to the COS's proposed central board (see below).<sup>85</sup> From within the Fund, Lord Lister, pioneer of antiseptics and the first medical peer, propounded this view. He pointed to the need for careful investigation as the proposed board was 'a body which represents all that is best in the Medical Profession in London, combined with the widest experience in Hospital management'.<sup>86</sup> The Prince wanted no outside influence and pushed for a separate distribution committee. This was not initially possible as the Fund was too preoccupied with the basic organisation to adopt any firm policy on distribution. At first it utilised the information collected by the Sunday Fund to aid its distribution as it was 'conscious that they were not qualified to undertake that thorough investigation into the merits of individual hospitals which is needed'.<sup>87</sup> A Distribution Committee was finally established in December 1898 and subsequently met for one month annually to allocate the grants. As a non-elected body it reflected the autocratic nature of the movement, breaking with the established cultural norm for a voluntary society and even with the hybrid benevolent funds as no effort was made to duplicate the voluntary associations' 'subscriber democracy'. All members of the Fund's administration were personally selected by the Prince to ensure a breadth of opinion and to defuse any potential disputes. Lord Lister, however, strongly influenced the Distribution Committee's foundation. Though he was unable to persuade the Prince to agree to any cooperation with the proposed central board, he did involve Sir Trevor Lawrence, treasurer of St.Bartholomew's and an important force behind the central board, in its activities.<sup>88</sup> This was supplemented by a visiting committee primarily selected by Lister. It sent two 'dispassionate' representatives, one medical, one lay, to investigate each hospital that applied for a grant. This was the first committee of its kind, but strangely, given the Fund's reforming intentions, it refused to

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<sup>85</sup> Rivett, *Development of the London Hospital System*, 148.

<sup>86</sup> KF Archive, Correspondence, KE/751/2.

<sup>87</sup> *BMJ* 1 (1898), 37-8.

<sup>88</sup> KF Archive, Distribution Committee, KE/20/1.

publicise the information collected as it did not want unduly to embarrass the hospital concerned.<sup>89</sup>

The Prince of Wales Hospital Fund employed the Sunday Fund's procedures and placed them on an explicit footing, as reformers continued to believe that improvement could only be effectively secured through a voluntary model of centralisation supported by financial incentives. Lord Rothschild expressed concern that the Fund would be criticised as a body that would want to influence hospital management as it aimed only to distribute money 'to the hospitals which they thought were best managed'.<sup>90</sup> This was precisely how the Fund was conceived and hospital reformers gave their support to the movement on these grounds. It departed from the Sunday Fund by not using grants to reflect an individual hospital's utility, but reinvigorated the principle of using grants to stimulate reform guided by a humanitarian, patient-centred ethic.<sup>91</sup> The Prince of Wales Hospital Fund became in effect a mass subscriber through its grants and therefore assumed the right to influence management for the benefit of the patients and not from individual institutional interests. The promise of an annual grant remained a powerful reforming incentive, though no formal pressure was applied.

Grants were set at a maximum of £5,000 in recognition of the Fund's limited resources. Begging letters were received from all directions, but the movement was dedicated to the hospitals' cause and initially devoted special attention to the seventeen hospitals with over 100 beds within seven miles of Charing Cross, as it was believed that these institutions held the greatest benefit for the nation.<sup>92</sup> Each grant had a specific intention and it was felt that any hospitals that cooperated should receive a similar grant for the following year.<sup>93</sup> A clear idea of what was expected was always given. The London Lock Hospital was awarded £500 on condition that the drainage was improved and overcrowding reduced; the West London Hospital received the same amount to reduce

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<sup>89</sup> *BMJ*, 2 (1898), 196.

<sup>90</sup> *Standard*, 4 February 1898.

<sup>91</sup> Prochaska, *Philanthropy and the Hospitals*, 53.

<sup>92</sup> KF Archive, Correspondence, KE/567; Executive Committee, KE/27/1.

<sup>93</sup> KF Archive, Distribution Committee, KE/20/1.

overcrowding. Other grants had a direct medical purpose: the East London Hospital for Children received £250 towards a new operating theatre.<sup>94</sup> However, it was generally assumed that because bureaucracy was modest any improvement in administration that the grants would promote could be equated with an advancement in healthcare. The Sunday Fund had never been so precise, merely using its grants to promote efficiency.

Grants did have a positive effect. In 1898 the governors of the London were asked if they had used the previous year's grant of £5,000 to improve the hospital's wards. Holland replied anxiously that a building committee had been established to spend £100,000 on improvements, and asked for patience. Under these circumstances the Fund agreed to award a further £5,000 in 1898.<sup>95</sup> Influence is perhaps more clearly displayed in the Fund's initial policy to use grants to reopen wards, which was equated directly with medical progress. Within the first four years 433 beds were reopened, the equivalent of two large hospitals.<sup>96</sup> University College Hospital immediately acquiesced to this policy; Guy's proved obstinate, resisting the Fund's suggestions. Although Guy's was awarded £6,600 of a £7,912 grant to reopen beds, the governors insisted that the money would be better used to build a nursing home. They argued that reopening all the beds would involve a removal of the paying patients that would ultimately prove more expensive. In the end a compromise was reached: 43 of the 154 closed beds were reopened, ironically reducing hospital provision for the middle classes.<sup>97</sup>

The Prince of Wales Hospital Fund rapidly assumed the influential position that Adrian Hope, secretary of the Hospital for Sick Children, had envisaged at the inaugural lecture of the Hospital Officers' Association in 1902.<sup>98</sup> Its influence was almost guaranteed because of the financial pressure it wielded. This was not unique given the Sunday Fund's activities, but it marked a new departure for philanthropy. The view that contributions could be used to influence hospitals' administration was reinvigorated by the

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<sup>94</sup> *Times*, 31 December 1898, 6.

<sup>95</sup> KF Archive, Distribution Committee, KE/20/1.

<sup>96</sup> B. Abel Smith, *The Hospitals 1800-1948* (1964), 183.

<sup>97</sup> Guy's Archive, General Court Sundry Papers, A1/4/6.

<sup>98</sup> *Hospital*, 22 November 1902, 133-5.

Prince of Wales Hospital Fund, taking over the role of the active citizen and replacing the citizen with a funding institution. The link between funding and reform was explicitly made and the Fund set about using its influence in what it considered was a positive manner. Charitable influence was revitalised, even if the problems of hospital finance could never be solved with the resources available given the competitive nature of the benevolent economy.

### 3. A CENTRAL HOSPITAL BOARD

The second strand of the debate on state intervention focused on the need for coordination, stimulating discussion among reformers. Some form of central coordination had long been a tenet of hospital reformers' ideas as a possible solution to the problems of competition between hospitals, duplication of services, and overcrowding in the central and northern districts. However, in an atmosphere openly hostile to state intervention arguments for organisation were conducted within the language of voluntarism. The debate focused on calls for a voluntary central board as a counter to state organisation and mirrored debates within the LCC over the need to centralise services.<sup>99</sup>

As early as 1796 Sir William Blizard, surgeon at the London, had suggested a central board, as had the *Pall Mall Gazette* in 1868, but it was in the 1880s that these views resurfaced into the public domain.<sup>100</sup> In 1883 Burdett, dissatisfied with the Sunday Fund's achievements, proposed a voluntary central body and Dr Francis Sutherland suggested a similar scheme to the BMA in 1888.<sup>101</sup> These views fitted within more practical moves to establish voluntary coordination, such as the COS's efforts and Graham Wallas's ultimately unsuccessful attempts to coordinate those charitable organisations in London that were providing meals for needy schoolchildren.<sup>102</sup> However, it was the

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<sup>99</sup> Rivett, *Development of the London Hospital System*, 144.

<sup>100</sup> Cited in *Charity Record & Philanthropic Messenger*, 31 March 1868, 103.

<sup>101</sup> C.S.Loch, 'The Confusion in Medical Charities', *Nineteenth Century*, 32 (1892), 308; Burdett, 'Our Hospitals', 381-2; *BMJ*, 2 (1888).

<sup>102</sup> A.M.McBriar, *An Edwardian Mixed Doubles: The Bosanquets versus the Webbs* (Oxford, 1987), 91.



suggestion made by the Select Committee on Metropolitan Hospitals that an informal central board should be established to help solve the problems facing London's hospitals that acted as a major stimulus to debate. The Select Committee found these views more acceptable than a state oriented approach, but was not confident enough to give them a full endorsement. Sandhurst, as chair of the Committee, was aware that support for the idea of a voluntary central board would help promote charity and prevent state action and suggested it on these grounds.<sup>103</sup> Because of the vague nature of its proposals, uncertainty prevailed and there was no immediate effort to carry out the Select Committee's suggestions. Without any concerted pressure or firm agenda for action the matter was left hanging and parochial concerns and the sheer number of interests involved slowed the development of a positive solution.

The Select Committee helped to establish a consensus that favoured a definite central board. Suggestions were made, chiefly by Burdett and the *Lancet*, that the Sunday Fund should be revitalised.<sup>104</sup> In 1892 a conference called in the wake of the Select Committee's report to discuss the issue, ascribed an important role to the Sunday Fund.<sup>105</sup> However, partly because Douglas Galton, general secretary of the British Association and an authority on hospital construction, successfully resisted all moves towards centralisation, the conference only recommended a further investigation, a position that the *BMJ* saw as a 'fiasco'.<sup>106</sup> Predictably the COS, which had been the main inspiration behind the Select Committee, took over. The COS, in calling for a voluntary and representative central body, shared Sandhurst's assessment and believed that it would counter moves to municipalisation, becoming the 'universal panacea' for the hospitals' problems.<sup>107</sup> Colonel Montefiore was the main force behind the COS's initiative and constantly campaigned for a central board, but serious plans only emerged in 1897. The *Charity Record & Philanthropic News* was critical, warning that hospitals' disinclination

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<sup>103</sup> *Charity Record & Philanthropic News*, 12 (1892), 251.

<sup>104</sup> *BMJ*, 1(1893), 312.

<sup>105</sup> *BMJ*, 1 (1893), 184.

<sup>106</sup> *BMJ*, 2 (1892), 314-5.

<sup>107</sup> *Charity Organisation Review*, (1896).

to cooperate would allow the COS to dominate. Burdett realistically regarded the COS's proposed arrangements, which had 169 representatives and included general practitioners, as impractical.<sup>108</sup> Burdett disagreed with the COS's ill-informed meddling and overt emphasis on character. For him the Society lacked the necessary experience of hospital management to be effective. He believed its intervention would prevent any concerted improvement, frustrating the aims of reformers like himself. Burdett's assessment proved accurate as the COS's recommendations were cumbersome and dismissed by governors who had never been extensively canvassed for their opinion.<sup>109</sup>

The COS did not form the first central board, but its involvement in the debate and the antagonism it generated was influential in its foundation. The twelve teaching hospitals independently met and established their own Central Hospitals' Council for London in 1898, effectively excluding the COS.<sup>110</sup> At a time when the structure of university education in London was under discussion by a Royal Commission from 1892 to 1894, and with the introduction of legislation to reorganise the University of London, the concerns over hospital reform and the COS's interests may have been less significant than would at first appear.<sup>111</sup> Certainly the Council was a central board that hoped to discuss the provision of medical care in the metropolis, but it may also have been an attempt by the teaching hospitals to strengthen their hand in the negotiations over the revised London University. Without any real power and lacking the authority and financial incentives of the Sunday Fund or Prince of Wales Hospital Fund, the Council proved ineffective. The *Charity Record & Philanthropic News* warned that a central board would drive many of those active in hospital management away, but governors took little interest in its work, and the Council seldom assumed the lead, preferring to procrastinate until the hospitals had virtually decided policy of their own accord.<sup>112</sup> However, never before had a body existed in which the capital's hospitals, albeit of a

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<sup>108</sup> *Times*, 11 November 1897, 6.

<sup>109</sup> FWA Archive, C/A26/9-10; C/A44/1.

<sup>110</sup> *BMJ*, 2 (1897), 1608.

<sup>111</sup> N.Harte, *University of London* (1986), 146-158.

<sup>112</sup> Rivett, *Development of the London Hospital System*, 152.

limited number and character, cooperated with the general aim of organising a representative body. The Council reinforced the notion of voluntary centralisation in a practical representative context rather than through funding or state intervention. The model it pioneered was adopted by other bodies in the twentieth century like the British Hospital Association and the London Voluntary Hospitals Committee that succeeded it.

Neither the Prince of Wales Hospital Fund nor the Central Hospitals' Council were ideal solutions to the problems facing the London hospitals at the end of the nineteenth century. The two movements were founded in a climate where state intervention had become an object of anxiety, and as a result they were attempts to counter the need for public assistance within a voluntary framework. Ultimately both proved unsuccessful. The Prince of Wales Hospital Fund was an effective funding body and became the champion of the voluntary system, but it addressed a financial situation that increasingly escalated beyond charity's ability to provide the resources. The fault did not rest with the Fund, but with the changing nature of the hospital and the demands of medical care. In the late 1890s voluntarism had reasserted itself in the face of state intervention, but the result was only to postpone the eventual outcome as healthcare created problems and demands that charity could not successfully meet.

## 1898 and Beyond

1898 was a more stable year for London's hospitals in comparison to the uncertainties of the early 1890s. Governors and concerned contemporaries worried about the hospitals' level of debt, but this now appeared more of an institutional problem than a metropolitan one. The debate over the abuse of the capital's outpatients' departments continued to occupy the medical press, revealing the general practitioners' persistent antagonism to the hospital, but fewer calls were now being made for state intervention. Advances in medicine had increased the medical profession's status and altered the public's perception of the hospital. Admissions remained high and many patients who had previously shunned the hospital now appeared willing to wait up to six hours for treatment.<sup>1</sup> Charitable contributions continued to be fitful and unpredictable, but the foundation of the Prince of Wales Hospital Fund had created a new mood of optimism.

Optimism concealed half a century of change and several structural problems. Hospitals had been forced to evolve with medical science and changing attitudes to poverty and welfare. A delay existed between external changes and hospitals' adoption of new practices, which were at best non-uniform given the institutions' and medical profession's innate conservatism. However, by the 1890s hospitals had moved further away from their philanthropic origins, becoming the top level of the medical care hierarchy. The sick poor remained the prime objects of attention, but now the hospitals' aim was to heal the sick as best they could, and moral reform and religious observation were marginalised in its objectives. Governors, despite their theoretical control of admissions, no longer dictated which patients were 'deserving' of treatment and their moral and superficial medical assessments had been replaced with a system guided by the doctors and based on medical seriousness. A distinction continued to be made between deserving and undeserving cases, especially in the debate over hospital abuse, but many now admitted that the categories had shifted towards a more medical perspective. Changes in medicine altered its theoretical basis and slowly introduced new techniques and departments into the hospital, depersonalising treatment.

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<sup>1</sup> *Charity Record & Philanthropic News*, 18 (1898), 380.

In such a climate, which increasingly favoured medical knowledge, a paradox existed. The medical profession had acquired an increased social status, though not the prosperity that it aspired to.<sup>2</sup> Within the hospital, however, the profession's scientific rhetoric, improving social status, and surgical ability made the medical staff junior partners in the administration rather than placing them in the dominant position that the hospitals' increasing medicalisation would suggest. In the specialist hospitals, doctors played a more prominent role than many of their counterparts in other medical institutions, but their authority was still restricted. Nowhere was the transition a smooth one. In the Poor Law, medical officers were excluded from even a junior partnership until the twentieth century. In the London hospitals it was the governors who remained in control, though a change in the hospital's nature had led them to rely more on the advice of their medical staff. The hospitals' function might have changed, but as an institution they continued to be dominated by the voluntary ethic.

The structural transformation of welfare provision, encouraged by the increasing scale of economic organisation, the inadequacies of local finance, demographic change, the impact of collectivist arguments, and an altered attitude to the nature and causes of poverty, suggested 'a mixed economy of welfare'. Between 1906 and 1949 welfare moved from the responsibility of the 'active citizen' to the 'active state', but the process was far from a linear one and voluntarism remained an important component.<sup>3</sup> In 1898, many of these changes still seemed unthinkable. Charity retained the upper hand in welfare and the faith in a minimal state gave it a limited, though increasing role. Even where social welfare programmes were to be initiated by the state, it was believed that they should be administered by elected local authorities in association with voluntary organisations. By 1914 increased taxation and extended state services had not dramatically affected the level of voluntary contributions. Civil society was practically committed to voluntarism, despite concerns that charity was becoming increasingly unable to solve the problems facing society, and an emerging collectivist school of thought that

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<sup>2</sup> See A.Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine 1720-1911* (Cambridge, 1994).

<sup>3</sup> F.K.Prochaska, *The Voluntary Impulse* (1988); G.Finlayson, 'A Moving Frontier: Voluntarism and the State in British Social Welfare 1911-1949', *Twentieth Century British History*, 1 (1990).

favoured an extension of the state's role. A new 'politics of conscience' had partly replaced the religious basis of voluntarism, but charity remained unguided by any single motive, appealing to a multitude of factors from guilt to gratitude. In comparison to the view that state aid through the Poor Law was impersonal - a view encouraged by means testing - many continued to praise philanthropy for its conviction, enthusiasm, freedom from restraint, and individualism, overlooking the uncoordinated nature of benevolence and the duplication of services. Hospitals were the 'flagships' of this benevolent system and internalised its ethics. At the end of the nineteenth century, their continued reliance on voluntary principles reflected charity's social importance. In the twentieth century, the London hospitals were the last major institutional bastions of voluntarism, outside provincial attempts to secure greater cooperation between the voluntary and statutory welfare sectors.<sup>4</sup>

The permeance of the voluntary ethic in hospital management was not matched in hospital finance where other sources of income had always been necessary. Contemporaries wanted to believe that hospitals were supported by voluntary contributions and in doing so they ignored its other sources of funding. Governors shared this preoccupation, inventing new strategies to encourage support from London's highly competitive benevolent economy. However, in 1873 the *BMJ* had already concluded that on average London's hospitals only received approximately 30% of their income from philanthropy.<sup>5</sup> By the 1890s it was becoming increasingly evident that they could no longer rely on the sweepstake of philanthropy if they wanted to survive. As one contemporary wrote in 1894, 'a glance at the advertising columns of any of the leading newspapers reveals only too clearly that the existing [charitable] sources of hospital income are fatally deficient'.<sup>6</sup> Governors and hospital reformers exaggerated the hospitals' financial problems, but it was inescapable that charity's relative financial contribution was falling. Direct philanthropy had never been the hospitals' sole source

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<sup>4</sup> See M.J.Moore, 'Social Work and Social Welfare: The Organisation of Philanthropic Resources in Britain 1900-1914', *Journal of British Studies*, 15 (1977), 84-104; M.Cahill & T.Jowett, 'The New Philanthropy: The Emergence of the Bradford City Guild of Help', *Journal of Social Policy*, 9 (1980).

<sup>5</sup> *BMJ*, 2 (1873), 611.

<sup>6</sup> *Hospital*, 28 April 1894, 83.

of income, especially at the endowed hospitals, and governors had always sought other sources of funding. Over time, as the pressures on the hospital and benevolent economy increased, financial diversification became the key characteristic of hospital finance. A preliminary study of the Royal West Sussex Hospital, Bristol Infirmary, and the Norfolk and Norwich Hospital, shows that this process was not just limited to London, though in London diversification was more marked.<sup>7</sup> Similar pressures were found in the Poor Law where financial diversification went hand in hand with a modification of the Poor Law's remit as it expanded to increasingly care for the non-problematic poor. Financial diversification was a product of the institutional provision of healthcare that developed beyond the ability of traditional sources of funding (be it the poor rate or philanthropy) to meet spiralling expenditure.

An anonymous hospital secretary explained to the *Charity Record & Philanthropic News* in 1894 that governors spent too much time worrying about the future, but 'somehow or other the hospitals were maintained in spite of the anxieties of the committees'.<sup>8</sup> It is perhaps because governors did not rely on any one source of funding, but haphazardly developed a diverse financial framework that they managed to survive institutional expansion and the transition away from their philanthropic base. In the Poor Law new sources of income had to be added to promote development and to allow it to take place. In the twentieth century these changes were to become more pronounced.

The optimism of 1898 quickly waned. The Prince of Wales Hospital Fund had not saved the London hospitals as contemporaries had hoped, and its continued popularity threatened the other benevolent funds' level of support. Charity had been temporarily stimulated to provide a solution to the London hospitals' apparent financial crisis, but no realistic attempt had been made to address the fundamental problems that the Select Committee on Metropolitan Hospitals had outlined.<sup>9</sup> Voluntary contributions through the Prince of Wales Hospital Fund were made into a substitute for reform, but they left a system of medical overcrowding and competition as charitable institutions scrambled for

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<sup>7</sup> Annual Reports 1850-1898.

<sup>8</sup> *Charity Record & Philanthropic News*, 14 (1894), 87; 4 (1884), 189.

<sup>9</sup> SC of the House of Lords on Metropolitan Hospitals, 3rd Report, *PP* 1892 XIII.

funds. Changes in how social problems were viewed began to modify the accepted solutions to the problems facing London's voluntary hospitals.

Between 1880 and 1914 the consensus that the 1834 Poor Law had taken social policy out of politics collapsed and a new feeling came to take its place. 'Social issues', noted Jose Harris, 'were no longer marginal to the major concerns of high politics' and 'among those whose main interest was in social questions, social policy was increasingly viewed as central to the effectiveness, the stability, and even the legitimacy of the state'.<sup>10</sup> The late nineteenth-century debate on the relationship of the London hospitals to the state was revived by the Liberal government's welfare reforms and the 1905-9 Royal Commission on the Poor Law. Poor-law medical service, freed from its pauper stigma by the separation of the infirmary from the workhouse, increasingly provided the main source of medical care for the sick poor. 'The small end of the wedge in breaking down status barriers between paupers and the wider community' had already been introduced into Poor Law with the inclusion of non-pauper patients through the MAB before the Local Government Board's decision in the 1900s to allow a system of 'statutory disregards' which permitted people to claim relief without forfeiting small private savings.<sup>11</sup> Both marked a change in attitudes towards relief. However, the Poor Law lacked the sophisticated medical services and educational function associated with the hospital. This left a gap in provision and raised important questions over the nature of healthcare. A number of Poor-law medical officers giving evidence to the Royal Commission, called for the establishment of a national health service, developing Sidney Webb's and Henry Burdett's earlier muted sympathy for coordination.<sup>12</sup> The BMA was scandalised and again declared its opposition to state intervention. Neither the *Majority* nor *Minority Report* approved of government intervention, but both recognised the need for reorganisation.<sup>13</sup> In effect the 1911 National Insurance Act provided a political

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<sup>10</sup> J.Harris, 'The Transition to High Politics in English Social Policy 1880-1914' in M.Bentley & J.Stevenson (eds.), *High and Low Politics in Modern Britain* (Oxford, 1983), 62-63.

<sup>11</sup> Harris, 'Transition to High Politics', 72.

<sup>12</sup> S.Webb, 'The Reform of the Poor Law', *Contemporary Review*, 58 (1890); H.C.Burdett, 'Our Hospitals', *Nineteenth Century*, 13 (1883).

<sup>13</sup> J.Brand, *Doctors and the State* (Baltimore, 1965), 201-205.



substitute for any revision of the existing arrangements; few seemed prepared to counter any other solution than a voluntary one in hospital provision. The London hospitals maintained their independence until the 1940s, but cooperation increasingly became a matter of political discussion. The growing complexity of Poor-law provision, an overlap of services for the sick, and the education of the population in municipal socialism through the MAB, made many aware as early as the 1910s that the system was in need of a radical overhaul.

An increasing awareness that the state might have to intervene in the voluntary hospitals was intensified by their financial condition. The growth of the 'active state' was part ideological, part economic, and part social, but within the London hospitals it was practical financial issues that served to alter governors' attitude to the state. The First World War had created a short-term reliance on government funding that by 1919/20 left the London hospitals facing an acute financial crisis. Under these conditions fears resurfaced within the hospital sector about the possibility of state intervention. The Medical Consultative Council set the tone in 1920 realising that any government assistance would be 'the beginning of the end, and not many years would pass before the hospitals would be "provided" for out of public funds'.<sup>14</sup> It could not, however, escape the need for state aid and recommended that financial assistance should be made the reward for greater coordination. The new Board of Health was uninterested and the government was determined to cut spending, and to avoid positive action the Hospital Commission was established under Lord Onslow to distribute a £500,000 grant.<sup>15</sup> 80% of the first year's grants went to London, but they were discontinued because the hospitals' financial position started to improve with the growth of working-class contributory schemes, which reduced debt but put hospitals on a quasi-insurance basis.<sup>16</sup> Ideologically the grants had challenged the hospitals' voluntary principles, but indirect state funding had already emerged during the First World War. To meet the problems of wartime healthcare, local authorities had negotiated contractual agreements with the

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<sup>14</sup> R.W.Chalmers, *Hospitals and the State* (1928), 119.

<sup>15</sup> J.Pater, *The Making of the National Health Service* (1981), 12.

<sup>16</sup> S.Cherry, 'Beyond National Health Insurance. The Voluntary Hospitals and Hospital Contributory Schemes: A Regional Study', *Social History of Medicine*, 5 (1992), 466.

hospitals on a financial basis, adapting their existing financial relationship with Poor-law unions. After the war the relationship was strengthened and hospitals became increasingly reliant on the income these agreements generated. In Manchester, government contributions provided 7% of hospital income; in Norfolk and Suffolk this was between 4-9% in the interwar period.<sup>17</sup> By the 1930s both the LCC and the hospitals accepted that grants had become a necessity. The London hospitals' financial position had introduced short-term government grants and long-term financial dependence on state funding into the voluntary system where in the 1890s it had been resisted. An unwilling precedent had been set and the development of the hospital further away from its charitable origins made state funding increasingly more attractive in practical, if not ideological terms. It became increasingly clear that voluntarism was ill-suited for effective medical administration and that charity was unable to meet the hospitals' financial needs without limiting provision and leading to the widespread closure of beds. The same phenomenon had been apparent much earlier in other welfare sectors. Under these conditions few avenues seemed open other than state funding and control, though debates over the nature of such a health services and the strength of the voluntary ethic in hospitals, and within the medical profession slowed the adoption of any scheme. In 1947 the same state intervention, even taking over the hospitals' accumulated debts, helped ease the acceptance of the NHS where governors had previously objected to the 1944 White Paper.

In the twentieth century the hospitals' finances were to become a central feature in the state's gradual assumption of the full financial burden of healthcare. In the nineteenth century financial concerns underlay the debate over hospital reform. A new charitable 'zeal' was suggested because no other alternative to voluntarism could be realistically considered. Money from direct philanthropy, however, was already insufficient to meet the London hospitals' needs and where the administration remained dominated by voluntarism, charity had long been diluted in the hospitals' finances. The two were not incompatible and governors continued to seek charitable funding, but as the hospital developed the unacceptable possibility of state intervention increasingly became the only realistic option.

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<sup>17</sup> J.V.Pickstone, *Medicine and Industrial Society* (Manchester 1985), 252; Cherry, 'Beyond National Insurance', 465.

# **Appendix**

## Appendix: Financial Sources and Methodology

### 1. PROBLEMS OF EVIDENCE

This study has been based on the financial information contained in the financial records (mainly cash books, receipt books and ledgers), Annual Reports and public financial statements of the seven hospitals studied.<sup>1</sup> Contemporaries complained that hospital accounts were idiosyncratic, complicated and confusing. They believed that this presented problems which prevented satisfactory institutional comparisons. For administrators, as Pinker has shown, this could be beneficial, allowing them to conceal any debt or irregularity.<sup>2</sup> Lax procedures were publicised, often with an incredulous tone. In 1890 the *Hospital* reported that St.John's Hospital for Diseases of the Skin kept its accounts 'upon loose sheets of paper' which had become muddled. In the records 'amounts appeared twice' and items could not 'be traced and totals cannot be made to agree'.<sup>3</sup> Many believed that these problems were widespread.

Concern manifested itself in a campaign led by Henry Burdett and the Metropolitan Hospital Sunday Fund (founded in 1873) for a uniform system of accounts, a move partly inspired by a desire to prevent embezzlement and to allow a comparison of institutions so that their relative utility and efficiency could be assessed as a guide to contributions. The Metropolitan Hospital Saturday Fund (founded in 1874) also applied pressure for uniform accounts, borrowing the Sunday Fund's schema. Their efforts were not entirely successful and not all hospitals were willing to follow their suggestions. For example, in 1886 Burdett could still complain that University College Hospital's accounting was 'not intelligible'.<sup>4</sup> For the historian this would present numerous problems, especially as time and storage have ensured that many financial records are no longer available or appear out of context. However, hospital accounts are not as confusing as contemporaries made out. The foundation of the Sunday Fund and Saturday Fund forced a measure of standardisation from the mid-1870s and all hospitals that wanted to receive a grant from the Funds had to adopt their classifications. Most accounts, however, were already arranged in a double-entry format. By balancing the

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<sup>1</sup> See bibliography for each hospital and financial records used.

<sup>2</sup> R.Pinker, *English Hospital Statistics 1861-1938* (1966), 142-3.

<sup>3</sup> *Hospital*, 1 February 1890, 286.

<sup>4</sup> UCL, UNOF/2/3 (2).

hospital's internal financial records with financial decisions made in committee meetings, the balance sheets bound in annual reports, and contemporary evidence in journals and periodicals, it is possible to create an accurate picture.

## 2. CLASSIFICATION

Hospitals and contemporaries used a standard terminology in their classification of income. In 1869 Burdett and William Laundry drew up a uniform system of accounts that was adopted by the Sunday Fund and Saturday Fund and revised by the Prince of Wales Hospital Fund in 1906.<sup>5</sup> The funds presented the ideal model for accounts and when they framed their classification they used the terminology hospitals used. Most terms are self-explanatory and follow standard dictionary definitions. In this study these classifications have been used to analyse hospital finance.

Hospitals divided their income and expenditure into two categories: 'ordinary', which included income and expenditure that were seen as annual and 'reliable', and 'extraordinary', income and expenditure that were infrequent or unpredictable. In this last category such items as legacies or the cost of building were covered. For income, the term 'extraordinary' allowed hospital governors to present income in terms that would not create the image that they were a well-funded institution, an impression that would limit their public appeal. For expenditure it concealed extravagance and presented the image that the hospital was normally run on economical lines. This vocabulary was used to ensure that the right impression was created.

Philanthropic income was separated into: donations (one off gifts), subscriptions (annual payment of a set sum), legacies (amounts left by will, including those for endowed beds which were usually listed separately as extraordinary income), income from the various benevolent funds which was recorded under their name (ie Sunday Fund, Saturday Fund, Prince of Wales Hospital Fund etc.), collections (collection boxes, street collection, church collections) and entertainments (plays, concerts, etc.). Each annual report contained a list of contributors which recorded the amount given as a donation or subscription. Where an individual gave both, these were listed separately. Charity bazaars, annual dinners, balls, and public appeals, if not listed separately, were included in the accounts as a donation, though the figure they raised was always recorded in the minutes. No all hospitals used the separate terms for entertainments and collections. These could be listed as separate events or more commonly placed with donations.

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<sup>5</sup> See H.C.Burdett, *Uniform System of Accounts for Hospitals & Public Institutions* (1893).

Non-charitable income was less complex and related more closely to the source of income. This wide category included: dividends (interest on investments), rent (from land or house, the two were not separated), sale of investments/property, sale of waste material, loans, deposits (money held on deposit, not the income from the interest it generated which was included under dividends), nursing (probationers' payment for their training and additional money from the hire of nurses was distinguished), payment from patients (separated into money from inpatients and outpatients), payment from public authorities (ie Poor Law, MAB) though this was often listed as patient payments, money from additional services (includes use of hospital baths etc.), college or medical fees, insurance (premiums or a claim made) and trust funds for scholarships or prizes.

Contemporary classification can be further subdivided, as shown in table A.

Table A: Classification of Income

Category	Sources of Income Included
Direct Philanthropy	Donations, Subscriptions, Legacies, Entertainments, Collections, Any money given as a voluntary gift.
Indirect Philanthropy	Sunday Fund, Saturday Fund, King's Fund, Individual, hospital collection schemes.
Hospital Property	Rent, Dividends, Deposits, Sale of Stock/Property, Sale of Waste Material, Insurance.
Hospital Function	Patient Payments, Nursing ,Fees, Medical Services ie. Patient baths, Public Authorities ie Poor Law Unions.
Loans	
Balance	Income left over from previous year
Sundries	Small amounts of income not classified

These classifications are illustrated and explained in more detail in Chapter 3.

### 3. METHOD OF CALCULATION

Three reference periods have been selected to illustrate change and development over the period: 1850-1855, 1875-1875 and 1890-1895. For each period a five-year average has been calculated to produce an overall figure. By using such an average, annual fluctuations in income are smoothed to present a more accurate representation of each source of income's relative financial contribution to the overall structure of funding.

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D5/13-19	Financial Journal.
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A2/1-2	Court of Governors Minutes, 1867-1921.
A3/1-2	Medical Committee Minutes, 1867-1907.
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A5/1-2	Finance Committee Minutes, 1878-1901.
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*Peter Pan Gallery & Archive, Great Ormond Street*

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 GOS/5/1/3      Published Staff Rules.  
 GOS/5/2/2      List of Patrons and Officers of the Hospital.  
 GOS/6/1/1      Register of Life Governors, 1852-1890.  
 GOS/6/1/2      List of Life Donors.  
 GOS/6/1/4      Register of Donors, 1890-1897.  
 GOS/6/1/8      Register of Legacies, 1855-1885.  
 GOS/6/1/25-37 Register of Special Cots, 1868-1918.  
 GOS/6/2/1      Royalty Correspondence File.  
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 GOS/8/151-4   Letters and Press Cuttings Album.  
 GOS/8/162      Patients Correspondence File.  
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A/26/31	Scrapbook, 1870-1898.
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F/1	Treasurer's Ledgers, 1847-1901.
F/9/3-4	Legacy Register, 1844-1898.
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M1/11-26	Physicians and Surgeons Inpatients, 1883 & 1898.
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*University College Hospital Archive, University College London D.M.S. Watson Library*

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